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6 December 2003

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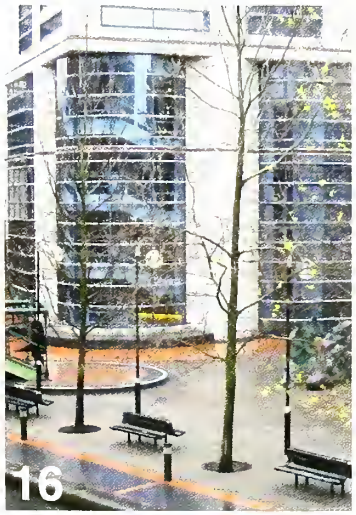

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As New Year approaches, giving up smoking will be one resolution many people will be making. Sarah Purcell looks at how the pharmacist can help prevent those resolutions from being broken

Regulars

Employers face bill for checks

Employee pharmacists and pharmacy technicians could face legal checks and land their employers with a £300 annual bill, under new proposals put forward by Home Office minister Hazel Blears.

Ms Blears, a former health minister, is proposing to clarify the scope of the checks by the Criminal Records Bureau under part five of the Police Act 1997 to include a range of named health professionals including pharmacists.

According to Mandie Lavin, RPSGB director of legal affairs and fitness to practice, this list could also be extended to include technicians once they become a registered profession next year.

Ms Blears's consultation document proposes to introduce more specific criteria in order to clarify the circumstances where those working with children or vulnerable adults would be eligible for an enhanced disclosure check. The proposals do not, however, make such checks mandatory.

Specific health professionals, including pharmacists, health visitors, GPs, nurses, dentists and midwives have been named in this.

And, as well as introducing an annual £300 registration fee for employers (or those requesting the check), the proposals also seek to increase the individual check fees – from £24 to £28 for the standard check and from £29 to £33 for the enhanced disclosure.

For its part, the RPSGB believes there is very little to concern members. Miss Lavin said: "Committing to public safety is important. Employers are increasingly aware of their responsibilities. There is already lots of good practice in pharmacy."

Earlier this year there was a furore when the CRB could not cope with checks required on new teachers. It is unlikely that the checks on pharmacists will be retrospective, but if they are endorsed, it will mean all pharmacists will have to be checked before they enter the profession. It could also mean checks on those moving to different practices.

For more information:

http://www.homeoffice.gov.uk/docs2/crimrecbureauconsult2.pdf

NHS Wales under pressure over delays in implementing pharmacy strategy

Welsh health minister Jane Hutt is coming under pressure over delays in implementing the Welsh pharmacy strategy.

Former nursing lecturer Val Lloyd, a Labour member of the National Assembly, asked recently whether Ms Hutt possessed any timetable for action over the *Remedies for Success* document published 15 months ago.

The minister replied that liaison was still continuing with the Department of Health in London on various issues, while the Welsh Pharmaceutical Committee of the NHS was giving advice on how to deliver. A source close to the talks said a major problem was the existence of England-and-Wales committees whose work was not timetabled to a Welsh agenda.

Ms Hutt said there had been "considerable progress" on supplementary prescribing, automation in secondary care, the review of community pharmacy services, repeat dispensing and direct supply of medicines.

PRACTICE

CHI praises Hull pharmacists

The Commission for Health Improvement has commended a community pharmacy accreditation scheme in Hull.

CHI clinical governance review for Eastern Hull PCT and West Hull PCT each identified the locally developed accreditation scheme as something that "the re of the NHS can learn from".

The Eastern Hull PCT review highlighted the resources the PC had invested in developing community pharmacists to support GPs, and noted that this support was valued. A communit pharmacist's involvement in a specialist diabetes service was highlighted.

The West Hull PCT review noted the number of positive medicines initiatives involving pharmacists, including smoking cessation, provision of EHC und PGD and a minor ailments scheme.

Graham Hill of East Riding ar Hull LPC was delighted that pharmacy had fared so well in th CHI reports. "Community pharmacy has an excellent workin relationship with both Hull PCT and it is extremely gratifying to see that CHI has recognised this, he said.

So far, 45 of the 60 pharmacies in the two PCTs have signed up t the scheme, which assesses pharmacists against a set of core clinical governance standards.

For more information:

www.chi.nhs.uk

C&D

Counterpart 2004

The cost of training materials an registration for the Cambridge Counterpart Pharmacy Assistant Training Course will increase wi effect from January 1, 2004.

Training packs (containing enough learning materials for fo students) will cost £25 (plus £4. VAT). The registration fee per student will be £35 (plus £6.13 VAT). Discounts are available o orders of 10 or more module packs.

For more information:

mprebble@cmpinformation.com

Tel: 01732 377269.

No comment from health minister

Health minister Rosie Winterton failed to respond to concerns over the proposed changes to the control of entry regulations.

Asked at an All-Party Pharmacy Group meeting on Monday whether the proposed measures would allow PCTs to effectively plan pharmaceutical services, she said she had not yet had feedback from the completed consultation.

On the new contract, she said the Department of Health was still aiming to reach an agreement by the end of March, with implementation soon after. But she said that discussions may continue beyond next March as the DoH was keen to "get the detail right rather than reach an artificial deadline".

Ms Winterton said she was unable to comment on the level of funding for the new contract.

Welsh central purchasing deal hits the rocks

Drug manufacturers have come close to killing off a proposal from the Auditor General that the Welsh NHS should switch to central purchasing of 300 primary care medicines.

Wales would save £50 million a year on a spending of £410m, according to the auditor general, Sir John Bourn.

But after a furious campaign by the drug manufacturing industry – which issued dire warnings that the National Assembly for Wales would be open to legal challenge if it went ahead with Sir John's proposals – the Welsh Cabinet has backed down.

However, it acknowledged that, while it is in favour of Sir John's proposal for centralised contracts, any move will have to fully take into account progress achieved by the Department of Health in London on purchasing of generic medicines. This could render centralisation inappropriate, the Cabinet said.

When the Cabinet's response was reported to the Assembly audit committee in Cardiff, Sir John delivered a stern response.

He warned drug manufacturers against trying to erect "red flags" to block his proposals. "We will be watching carefully and will report back if we see any backtracking on the part of the industry to promises it had earlier made to the committee," he said.

Audit chair Janet Davies vowed to maintain pressure on the industry. She said: "We are not suggesting that it should happen in one big bang. The £50m savings which are possible cannot be ignored by this committee."

When the report first appeared, Ann Lloyd, NHS director for Wales, said she would be tackling the cost problem "from the bottom up and from the top down" through some of the 22 new local health boards introducing formularies, and through introducing central buying for five or six of the most common drugs.

But the claimed strength and breadth of opposition from NHS interest groups was highlighted by the All-Wales Medicines Strategy Group – (AWMSG), an NHS adviser – at a specially enlarged meeting convened to reply to Sir John and the audit committee.

ABPI Wales claimed the reports advocating central purchasing were being driven "by a narrow concern to achieve short-term savings", which ignored the costs of research and development, and threatened the Pharmaceutical Price Regulation Scheme. To believe that cost savings achieved in secondary care through central purchasing can be replicated in the primary sector "represents a fundamental misunderstanding of how the market operates".

Also opposed to the Welsh NHS proceeding as recommended are the RPSGB, Community Pharmacy Wales, GPC Wales, a dispensing doctor, a community health council representative, and the All-Wales Drug Contracting Committee.

The audit committee had recommended that centralised contracts be pursued – but that the Welsh NHS should do so "on the basis of the proposals and advice that it receives from AWMSG".

Palliative care award

A network of community pharmacists offering palliative care medication and support has won the Napp Palliative Care Award.

The Tayside Community Pharmacy Palliative Care Network was set up in June 2002 and involved 15 pharmacists.

The aim was to provide more immediate access during out-of-hours to palliative care medication. The pharmacists within the network stocked medication such as diamorphine, that they would not normally have stocked, and this was reimbursed. The list of core drugs stocked was created by surveying key stakeholders, such as nurses, and then compared with a list available for a similar scheme.

The pharmacists also displayed Macmillan leaflets on cancer which were monitored and Macmillan is collating the data for a potential roll out of leaflets to other pharmacies.

Feedback has been positive and patient care has improved. Carers said the network meant no multiple trips to pharmacists to get care. The scheme has also raised the profile of pharmacists in palliative care.

Over 1,000 support petition for Charter referendum

The Save our Society (SOS) campaign presented a petition to the Royal Pharmaceutical Society on Tuesday evening, demanding a referendum on the new Charter.

Hassan Argomandkhah, who led the petition, collected 620 faxes and letters, 412 e-mails and 64 text messages in support of a referendum.

"Today's petition gives voice to individual members' rights to have the final say on the future of this profession," he said.

"The Council has continually argued that the issues are complex and a simple yes or no vote is not adequate. The SOS campaign says enough is enough of poor excuses and undemocratic ways."

All organisations, from local clubs to multinational companies, give members or shareholders a chance to vote on major changes to their articles of association, he added.

The members would not accept excuses such as lack of time, because as long ago as July the special general meeting had voted for a referendum on the final Charter.

Mr Argomandkhah was speaking prior to a Council meeting at which Nick Wood proposed that there should be a ballot of the Society's members to seek their approval for the proposals incorporated in the new Charter.

Mr Wood estimated that a referendum would cost no more than £25,000 – the cost of a Council election – whereas if there were no ballot there could be a risk of another SGM costing £28,000.

SOS campaigners, from the left: Nick Wood, Martin Astbury (hidden), Hemant Patel, Noel Wicks, Hassan Argomandkhah, Doug Simpson and Sultan Qyani with their petition

Another SOS Council member, Martin Astbury, said the group would still want a referendum even if Council amended the Charter to take account of the main objections in the latest consultation.

There were 430 responses to the first draft Charter and 245 to the second, which attracted many more criticisms than favourable responses. In both consultations, the main complaints have been over a statement that one of the Charter's objects is to safeguard the interests of the profession of pharmacy rather than the interests of members in the exercise of the profession.

During the Council meeting Mr Wood's motion was defeated, after members agreed on Charter revisions that they hoped would satisfy the objectors (*further details next week*).

The secretary and registrar, Ann Lewis, told the meeting that the Department of Health wants Council to take final decisions on the Charter this month, so the proposals can be taken into account when drafting new legislation governing the Society.

The legislation will take the form of an Order under Section 60 of the Health Act 1999, with a draft available for public consultation early in 2004.

To keep to this timetable, the new Charter must be 'petitioned' to the Privy Council next week, leaving no time for a referendum.

Hassan Argomandkhah later told *C&D* that the SOS campaigners would consider the legal position and any possible future action.

MEDICINES

MHRA issues OneTouch alert

Pharmacists should not dispense plasma-calibrated Lifesean OneTouch glucose test strips, following an alert from the Medicines and Healthcare products Regulatory Agency.

According to the MHRA, the strips, which are used with LifeScan OneTouch II, LifeScan OneTouch Profile and LifeScan OneTouch Basic blood glucose meters, give results that are 12 per cent higher than those given by blood-calibrated test strips.

The MHRA is advising pharmacists to check stocks of the test strips; the words 'Genuine 2 OneTouch test strips plasma calibrated' appear on the vials of the affected products. Lot numbers 207931A, 209917A, 203912A, 207022A, 207828A and 207132A have been identified as affected.

In addition, the MHRA is advising pharmacists to:

- identify patients with the plasma-calibrated strips
- replace plasma-calibrated strip with blood-calibrated strips
- advise patients to retest with the blood-calibrated OneTouch strips
- advise patients to contact their lead health professional.

LifeSean says the affected test strips have been imported without its knowledge or consent The company is advising pharmacists to quarantine plasma calibrated OneTouch test strips and return them to their wholesaler for replacement with whole blood-calibrated OneTouch strips.

For more information:

Lifescan UK

Tel: 0800 001210.

Questiontime

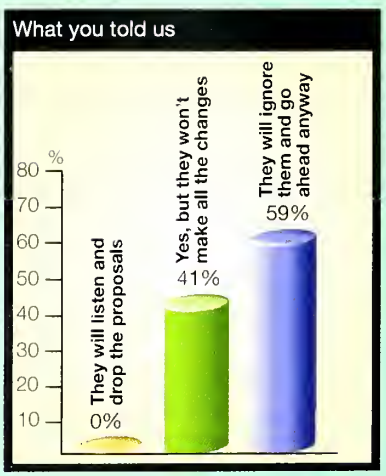
Sponsored by UniChem

Last week we asked you: "Do you think that the Government will take on board the NPA and the RSPGB's views in its proposals for control of entry?" You replied (see right):

This week's question: "The Christmas trading period is crucial to many businesses. How are sales figures in your pharmacy?"

- Better than last year
- Worse than last year
- Expect a rise in next fortnight
- Expect an improvement after Christmas

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on December 9 to cast your vote. We will publish the results in *C&D*, December 15.



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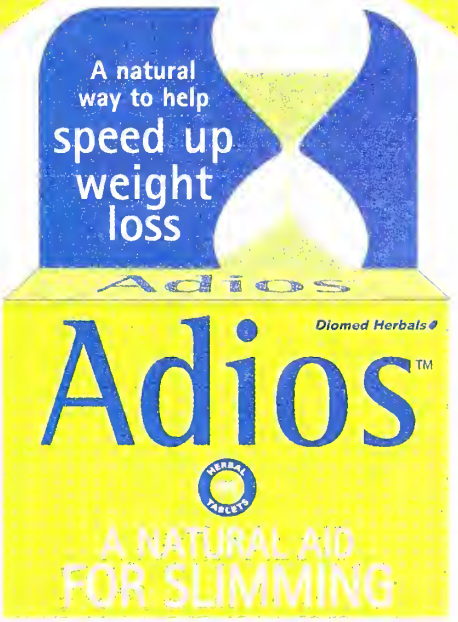

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ADIOS Trademark and Product Licence held by Diomed Herbals, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Directions:** Adults and elderly: Take one tablet three or four times a day at mealtimes, as part of a calorie controlled diet. **Indications:** A herbal remedy traditionally used as an aid to slimming. **Contra-indications:** Not to be taken by children under 16 years. Not to be used if allergic to any of the ingredients. Not to be used during pregnancy or lactation. Do not store above 25°C. **Legal Category:** GSL **Packs:** Adios (PL 17418/0005) - 100 tablets, RSP £9.95 (£8.47 exc. VAT).

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POLITICS

Entry proposals must go, say MPs

A group of 36 Tory and Ulster Unionist MPs has put forward a Commons motion urging the Government to shelve proposals arising from the OFT report on community pharmacies.

Led by the shadow cabinet co-ordinator for health and education policy Tim Yeo, the Tories' motion amounts to a warning to health and trade & industry secretaries John Reid and Patricia Hewitt that, if they try to implement parts of the OFT report and put pharmacies at risk, the Conservatives will vote against them.

The Government knows it would also face a substantial rebellion in the Commons and the threat of a defeat in the Lords. Given the febrile atmosphere in Parliament over student top-up fees, the Prime Minister is unlikely to want to take on another battle.

The motion, which has been signed by shadow health secretary Andrew Lansley, says there is widespread concern the new proposals would lead to the loss of many local pharmacies. It regrets the current consultation on the Government's proposals is limited to the implementation of them without giving those who retain serious anxieties the opportunity to make further representations.

It says pharmacists play an important role in the NHS and have the potential to take the pressure off the primary care sector and to improve the diagnostic capabilities of the health service.

The group called on the Government "not to press ahead with its plans unless and until it can clearly demonstrate that its proposals will not lead to the closure of large numbers of community pharmacies".

Charities cast doubt on reforms

Two public health charities are urging the Government to delay the control of entry reforms until the impact of LPS pilots and the new contract framework has been evaluated.

In a joint response to *Vision for Pharmacy*, Pharmacy HealthLink and the United Kingdom Public Health Association state that both of these service developments are key to the future of pharmacy. They say the healthy competition they will invoke will create user-centred services with potential gains for public health.

The charities feel the proposed exemptions from the control of entry regulations would fundamentally undermine PCTs' ability to plan pharmacy services.

PSNC

Limit exemptions, urges PSNC

Limit the scope of the proposed exemptions and end the financial uncertainty for community pharmacies, PSNC has urged in its response to the DoH consultation, *Proposals to reform and modernise the NHS (Pharmaceutical Services) Regulations 1992*.

Voicing concerns that the proposed exemptions remove the ability of PCTs to plan pharmacy service provision within their localities, PSNC warned that PCTs should not be left to respond to pharmacy applications in an ad hoc manner. It is concerned some of the proposals could result in unintended consequences.

On the exemptions, PSNC says:

Pharmacies based in shopping developments of 15,000sq m: the definition is currently too vague.

Open for more than 100 hours per week: PSNC can envisage a scenario where the 100 hours could be made up solely within the Monday to Friday period, with no opening at all at the weekend. This would seem to defeat the object of increased access that is intended.

One-stop primary care centres: any laxity in the scope of this exemption will fundamentally undermine the entry control system and the network, and thereby Government policy. These will be plum sites for service provision under the present and the proposed new contract, and will kill off many pharmacies in surrounding areas.

Mail order or internet-based pharmacy services: it must be ensured that the Medicines Act 1968 must not be used as a device to allow wholly internet/mail order pharmacies to be located at the rear of a drugstore or other retail location. This would be deregulation via the back door.

PSNC is urging the Government to drop its proposal to review the reformed control of entry system in 2006. "By 2006 it is inconceivable that the market will have completed its re-adjustment to the environment created by the new regulatory framework."

Summarising, PSNC says: "The new pharmacy contract being negotiated will require significant investment by pharmacy contractors to deliver the benefits to patient care which are envisaged. The current uncertainty around control of entry is adversely affecting investment."

Weight training in Barnet

Five Barnet pharmacists are running pharmacy-based weight management clinics in a six-month pilot. If successful it may be rolled out throughout Barnet after it concludes at the end of April next year.

The brainchild of the Barnet Pharmacists Study Group, the pilot uses posters and leaflets to invite patients to enrol for weight management, diabetes screening and blood pressure monitoring.

Patients identified as being at high risk are referred to their GP, those considered pre-obese or obese will be enrolled onto a six-month programme of six sessions of activity and healthy lifestyle counselling. The service is free to patients, and pharmacists are paid on a per client basis, up to a maximum of 15 clients per pharmacy and with mutually agreed terms. "This is a pilot and the pharmacists involved wanted to pro-actively develop this service," says Barnet Pharmacists Study Group chairman Bharat Shah. Sessions are taking around 45 minutes. Barnet PCT and Roche have provided the necessary training and support materials.

Mr Shah says that currently, over four out of five patients initially consulting about the scheme are enrolling.

ONLINE

CoMedis.com signs up Numark and NTL

by Sasa Janković
sjankovic@cmpinformation.com

Numark and its wholesaler division NTL have signed up as subscribing members to the pharmacy transfer order and information service operated by CoMedis.com.

Over 2,000 pharmacist users are registered to CoMedis.com so far and the company says this number could reach 3,500 by the end of the year. The site has just added two more manufacturers in the shape of Beiersdorf and Thornton & Ross and is about to launch a new refined search service to users called Profiling.

Peter Skinner, CoMedis.com business director, said: "We are delighted that Numark and NTL are new subscribing members to CoMedis.com.

"In addition, all Numark and NTL customers will be the first pharmacists, together with current CoMedis.com users, to be able to take advantage of a new service known as Profiling, where users have a full tailoring ability to search specifically against an individual manufacturer, OTC medicine or wholesaler/buying group affiliation for the best order price, aiding yet greater cost and time savings for the pharmacist."

David Wood, Numark and NTL chief executive, said: "For Numark members, being part of CoMedis.com will mean greater business efficiencies, thanks to the ability to review offers and information at the touch of a button, whenever they want. This will aid more effieient ordering, with the ability to be able to track and log orders with CoMedis.com giving our customers access to the most competitive prices."

CoMedis.com said the sign up of Numark and NTL will not affeet other wholesaling preferences and arrangements for delivery. Pharmacists ordering via CoMedis.com will still be able to choose whichever wholesaler they prefer to deliver all products.

For more information:

www.comedis.com

WHOLESALERS

EU moves to guarantee medicines supply

by Sasa Janković
sjankovic@cmpinformation.com

The European Association of Pharmaceutical Full-Line Wholesalers (GIRP) has welcomed the amendment to the review of EU pharmaceutical legislation by the Environment Committee of the European Parliament, to safeguard the flow of medicines between manufacturers, full-line pharmaceutical wholesalers and pharmacies.

GIRP president Jeff Harris reaffirmed the commitment of pharmaceutical full-line wholesalers to ensure high service levels and the uninterrupted supply of medicines in an enlarged Europe. However, he said full-line wholesalers are concerned they will not be able to guarantee the reliable distribution of all products due to supply restrictions by several manufacturers, which could put patients' health at risk.

By splitting the responsibility of pharmaceutical manufacturers and wholesale distributors, the amendment equally obliges manufacturers to guarantee the uninterrupted supply of medicines. This move is of vital importance to European citizens, since neither pharmacies nor wholesalers can fulfil their respective responsibility towards the patients without previously receiving the medicines from the manufacturers, Mr Harris said.

For more information:

www.girp.org

INDUSTRY

Galen sells PDMS to founder

Galen Holdings has sold its Pharmaceutical Development and Manufaeturing Services business for £20 million to a company under the control of founder and former chairman Dr Allen McClay.

PDMS provides a range of specialist services for the pharmaceutical, healthcare and biotechnology industries including drug product formulation, process development, analytical method development and validation, pack design, inventory management, eommercial scale manufacture and distribution.

As part of the deal, PDMS will continue to make, supply and distribute a number of Galen's produets for the UK and Irish markets. Roger Boissonneault, Galen chief executive, said: "As we expand, we no longer see contract manufacturing as a eore activity."

INDUSTRY

OFT asks for views on salbutamol inhalers

The Office of Fair Trading is asking interested parties to give their views following IVAX International's completed acquisition of 3M's distribution business for certain asthma products.

On October 20 the OFT announced the merger would be referred to the Competition Commission unless IVAX remedied competition concerns in the UK market for the supply of salbutamol breath actuated inhalers.

IVAX has offered not to increase the price of its salbutamol breath actuated inhalers until an effective substitute not manufactured or distributed by IVAX is available in the UK.

Before reaching a final decision, interested parties are invited to respond to the OFT on the proposed undertakings.

Representations on the acquisition should be made by December 18, 2003, to Samina Khan, Mergers Branch, OFT, Fleetbank House, 2-6 Salisbury Square, London EC4Y 8JX.

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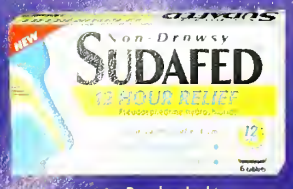

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*contains Pseudoephedrine and Ibuprofen

Sudafed is a registered trademark of Pfizer Consumer Healthcare.

Drowsy Sudafed Decangestant Tablets Product Information: **Presentation**: Tablets cantaining 60mg pseudoephedrine hydrochloride. **Uses**: Symptamatic relief af allergic rhinitis, camman cald and influenza. **Dosage**: One tablet every 4-6 hours as a day. Not suitable far children under 12 years. **Contraindications**: Hypersensitivity; severe hypertension, severe coranory artery disease, use af MAOIs ar furazalidone in preceding 14 days. **Precautions**: Mild-to-moderate hypertension, renal impairment, severe hepatic impairment, heart disease, diabetes, hyperthyroidism, glaucoma, prostatic enlargement. Tricyclic antidepressants, other sympathomimetic agents e.g. decongestants, appetite suppressants, amphetamine-like psychostimulants. May reverse hypertensive actian of drugs which interfere with sympathetic activity e.g. bretylium, bethonidine, guanethidine, debrisoquine, methyldopa and alpha and beta blockers. **Pregnancy & lactation**: Not recommended. **Side effects**: Sleep disturbance, skin rash, urinary retention, hallucinotions. **RRP (ex VAT)**: 12s, £1.83; 24s, £3.14. **Legal category**: P. **PL halder**: Pfizer Cansumer Healthcare, Chestnut Avenue, Eastleigh, Hampshire SO53 3ZQ. **PL number**: 15513/0024. **Date af preparatian**: October 2003

Drowsy Sudafed 12 Hour Relief Product Infarmation: **Presentation**: Modified-release tablet cantaining 120mg pseudoephedrine hydrachlaride. **Uses**: Symptomatic relief af allergic rhinitis, common cald and influenza. **Dosage**: One tablet every 12 hours, maximum daily dase 2 tablets. Not suitable for children under 12 years. **Contraindications**: Hypersensitivity; severe hypertension, severe caranory artery disease, use of MAOIs ar furazalidane in preceding 14 days. **Precautions**: Mild-to-moderate hypertension, renal impairment, severe hepatic impairment, heart disease, diabetes, hyperthyroidism, glaucoma, prostatic enlargement. Tricyclic antidepressants, other sympathamimetic agents e.g. decangestants, appetite suppressants, amphetamine-like psychostimulants. May reverse hypertensive actian of drugs which interfere with sympathetic activity e.g. bretylium, bethanidine, debrisaquine, methyldopa and alpha and beta blockers. **Pregnancy & lactatian**: Not recommended. **Side effects**: Sleep disturbance, skin rash, urinary retention, hallucinotions. **RRP (ex VAT)**: 6s, £2.55; 12s, £4.25. **Legal category**: P. **PL holder**: Pfizer Cansumer Healthcare, Chestnut Avenue, Eastleigh, Hampshire SO53 3ZQ. **PL number**: 15513/0034. **Date af preparation**: August 2003.

Drowsy Sudafed Dual Relief Max Product Information: **Presentation**: Tablets cantaining Pseudoephedrine HCl 30mg, and Ibuprafen 200mg. **Uses**: Symptomatic relief of cold and flu symptoms including nasal & sinus congestion with headache & fever. **Dosage**: Adults and children aver 12 yrs: 1 or 2 tablets every 4 ta 6 haurs, maximum 6 per 24 haurs. Under 12 yrs: Nat recommended. **Contraindications**: Hypersensitivity, heart disease, circulatory problems, kidney disease, peptic hypertension, diabetes, phaeachromacytoma, closed angle glaucoma, allergy to aspirin ar ather NSAIDs, concurrent use af tricyclic antidepressants, painkillers or decangestants, use of MAOIs in the past 2 weeks. **Precautions**: Asthma, thyroid, prostatic hypertrophy, renal ar hepatic impairment. **Pregnancy and lactation**: Not recommended. **Side effects**: Hypersensitivity reactians, insomnia, dizziness, excitability, anxiety, tremor, palpitations, dry mouth, nausea, dyspepsia, GI bleeding, loss of appetite, thirst, skin rash, chest pains, and less frequently muscle weakness, difficulty in micturatian, hallucinotions and thrambacytapenia. **RRP (ex-VAT)**: 12s, £2.55; 24s, £3.99. **Legal category**: P. **PL Holder**: Wellcehall Laboratories Beckenham Lane South, Taplaw SL6 0PH. **PL Number**: 00165/0109 Further information available from Pfizer Consumer Healthcare, Chestnut Avenue, Eastleigh, SO53 3ZQ. **Date af preparation**: August 2003.

MHRA strengthened as watchdog

by Sasa Janković
sjankovic@cmpinformation.com

The Department of Health has announced new measures to ensure companies accurately advertise medicines and that Medicines and Healthcare products Regulatory Agency investigations into complaints are more transparent.

The measures aim to strengthen the MHRA's role in three key areas: pre-vetting, investigating complaints and increasing the transparency of investigation outcomes.

As a result, the MHRA will increase the vetting of advertising material before it is published to ensure it complies with MHRA guidance.

The Agency vetted 13 products in the first half of 2003 compared with 15 in the whole of 2002.

It will also ensure publication of corrective statements to increase awareness of misleading adverts, improve the handling of complaints and publish reports on its website outlining the facts of the complaint and the outcome of the investigation.

Lord Warner, parliamentary under secretary of state at the DoH, said: "The public has a right to expect that medicines are advertised clearly and accurately, and the MHRA has a responsibility to take action quickly and effectively when companies fail to do so. The new measures will mean the MHRA can monitor and enforce regulations more effectively, with a greater level of transparency."

For more information:
http://medicines.mhra.gov.uk

Skipton is Lloyds' best

Lloydspharmacy in New Market Street, Skipton, has been named the national winner of the 2003 Lloydspharmacy, GlaxoSmithKline Academy of Excellence Award.

Formerly known as the Branch of the Year Award, the competition saw finalists from Glasgow, Bolton, Sheffield, Bristol, Basingstoke and Woburn all vying for first place.

Skipton pharmacy manager, Anne MacDonald, said: "The staff have enjoyed using their initiative, vision and sheer hard work to put forward the best effort and their results have paid off."

The final, on November 12 at the Belfry Hotel in Warwickshire, was judged by a panel of 14, including Lloydspharmacy managing director Mike Ward and representatives from Lloydspharmacy and GSK.

From left: Anne MacDonald, Pam Smith, Alison Swindells and [illegible] celebrating their award

"UniChem Brand lets us compete with high street prices and still show a profit."

Words of wisdom dispensed by Peter Badham of Badham Chemists, Bishops Cleeve

" Of course I want to make a profit. But I have to stay competitive if I want to survive – especially when competition is getting tougher by the day. That's why I stock UniChem Brand products. I can offer my customers the same high quality products, at a much lower price than the brand names. And the great thing is, I can pass these savings on to my customers and still come out on top."

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Comment from the Editor

The Prime Minister's 'Big Conversation' was launched last week. *Xrayser (right)* is sceptical, and perhaps with good reason. On a whole range of issues – from the war in Iraq to tuition fees and hunting – this Government has shown an amazing ability to override substantial, if not majority, public and parliamentary opinion in the dogmatic pursuit of policy.

The big question for community pharmacists is whether it will do so again on the control of entry issue. Some 180 submissions on the Government's 'balanced package of measures' were made by the time the consultation closed on November 21. *C&D* has reported the strongly felt concerns of both pharmacy and non-pharmacy organisations. We have yet to see a response which gives any support to the proposals.

Behind the well-reasoned arguments on the main points (*see p9 for PSNC's feedback*), there are other concerns. There is the timing. What is being proposed could come into effect at broadly the same time as the new contract in England and Wales, and it will have a knock-on effect in Scotland and Northern Ireland. There is also the sheer unworkability of what is being proposed. Both of these issues will have an impact on the various new contracts being negotiated or discussed across the UK. Trust and goodwill make such negotiations much easier, and in London the DoH's stance ha done little to generate much of either.

A further concern is that the DoH is dangerously underestimating the frustration building up, particularly among the larger pharmacy multiples, over the lack of joined up thinking in its vision of pharmacy in primary care. This encompasses not only control of entry but funding, IT, LIFT and a string of other issues. Ministers can expect some blunt talk after Christmas from this quarter. It is a slightly sour note on which to see the year out, especially when the new contract, which has genuine support, holds so much promise.

This Government has shown an amazing ability to override substantial, if not majority, public and parliamentary opinion

Yourviews

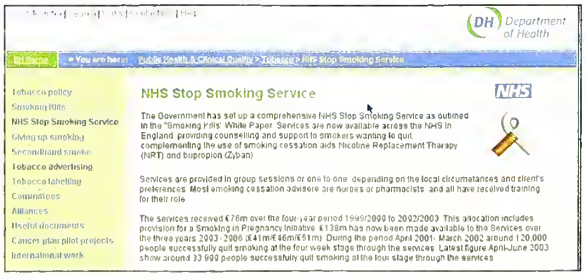
Alan Castell, a normally mild mannered pharmacist from Barking, gets tangled up in statistics

Statistics should carry a health warning

"There are three kinds of untruth: lies, damn lies and statistics," Benjamin Disraeli is attributed as saying. I was arrested last week by a newspaper report of a scheme to supply smoking cessation products (*C&D November 22, p9*). Apparently the health minister John Reid has negotiated a deal with NRT manufacturers to help 10,000 smokers quit. Somehow, 10,000 did not seem that many.

The next statistic was that the number of quitters in the first quarter increased by 10 per cent over the previous year. Quite impressive until the next statistic: the target for the next three years is 260,000, or 267,000 per year, of which 10,000 represents a measly 4 per cent.

Further on I read that the total number of quitters for 2002-2003 was 123,900. We need an increase of 115 per cent to hit targets.



The Department of Health's website on smoking cessation

However, it occurs to me that if half of community pharmacies (which in my area achieve 60 per cent plus quit rates) saw two clients a day, each would achieve 60 quitters a year, thus easily achieving this target. Why, we could eliminate smoking in less than 50 years. Perhaps this is why smoking cessation services have crept into the core (essential) part of the new contract.

Intrigued by these figures, I wanted more. Statistics can be addictive and I may be in serious need of counselling. Helpfully the report listed three statistical sites to explore and, believe me, they have more statistics than you can count. I find that in the past year 234,900 clients set quit dates and 53 per cent succeeded. Some 175,700 received NRT, at an average cost of £196 per quitter plus the cost of NRT or Zyban.

Nowhere could I find any clue as to why 267,000 is a target until, analysing another table (of the myriads) I find that this is roughly the number who start smoking annually. So we need 115 per cent more effort to break even.

Although most of these tables relate to those over 16, another table reveals that 56 per cent start smoking while still under 16, and most by 24. The majority of my clients are over 40, which is when the number of smokers start to decline. Why are our efforts so concentrated? Why don't we target the young?

Two more tables provide clues. One depicts the age of onset of smoking-related disorders, and the other, the revenue that the government receives from smokers. From the two it is possible to estimate the age at which smokers turn from a financial asset into a liability. Yes, it is 40 plus. All is explained by the wonder of statistics – tough luck on the teenagers though.

www.doh.gov.uk/public/hpssspub.htm

Northern Ireland NOTEBOOK

The heavy hand of the fraud squad

Some years ago, an extensive report highlighted that the Health Service was being subjected to significant fraud. For a long time there seemed to be a naive assumption that a public service designed to care for the nation's health would not be abused.

The report was shocking and recommended a number of action points, the most tangible for pharmacists being a change in the look of the prescription form. It is now printed on special paper and, I understand, under UV light displays the Giant's Causeway.

Pharmacists agreed for a fee of 3p per form (or was it item?), to become Health Service tax inspectors. Other less overt activities are ongoing, with greater surveillance on prescription exemption fraud by patients.

Some weeks ago a diabetic customer asked me what he should do with a letter he had received

Other patients asked similar questions suggesting I was being targeted

from the CSA Counter Fraud Agency. It required a response from him on a standard form. It asked him to prove his exemption status. More sinister was that it wanted to know if the pharmacist had asked for proof of exemption.

Over a further week or two other patients asked similar questions, suggesting I was being targeted. What concerns me is that if a patient was exempt but claimed that I did not check would I be penalised and would I be made aware of it? I do not condone fraud but I do expect that anti-fraud systems do not unfairly penalise me for not doing my job.

Perhaps time would be better spent prosecuting those committing the really big frauds.

Written by a practising pharmacist in Northern Ireland

TOPICAL REFLECTIONS

When will the penny drop at the DoH?

From the experience of everyday practice, and now as confirmed by a GP survey conducted by Lloydspharmacy, I know millions of GP hours are wasted each year dealing with patient problems which could be dealt with far more efficiently by the local community pharmacist.

Whether it is advice on head lice, smoking cessation, hayfever, nappy rash, colds and 'flu – the list is endless – I am the first port of call for many patients. But then I have to refer unnecessarily when the preferred medicine is a POM, no patient group direction is in place, or if the patient will not pay the cost of OTC treatment.

The new contract may soften a few of the edges but the fundamental problem is the inability of the Department of Health to understand the enormous contribution that community pharmacists could make to primary care if they were actively involved in its working structure.

It should be a standard instruction for all patients to first attend a community pharmacy when presenting with simple problems. Let me sort out whether a referral is necessary and provide me with the tools to deal with the rest under the umbrella of the NHS. Then the pressures on GP surgeries could be dramatically reduced.

Parallel imports back in the spotlight

If a report by researchers from the LSE on parallel importing is true then the Department of Health might well wish to look afresh at parallel imported drugs (*C&D November 29, p9*). The study looked at the cost savings to the health services of six countries, including the UK, compared to the profit made by the parallel importers. It concluded that the parallel importers retained the vast majority of the profits while the health services gained little.

The full study will be published at the end of the year but the quoted level of mark up on sales of 49 per cent does indicate that the parallel importers are more astute at marketing than I am at buying. Certainly when I buy PI drugs the percentage variation between suppliers is rarely as high as this level of mark up suggests it should be.

However, savings are made to the NHS drugs budget and perhaps the DoH would prefer to take some benefit rather than none. Some argue that the overall financial damage to the UK economy through a reduction in R&D activity outweighs the advantages of parallel trading but this is academic. Stopping parallel imports is illegal. That leaves the importers laughing all the way to the bank.

It's good to talk, but try listening too!

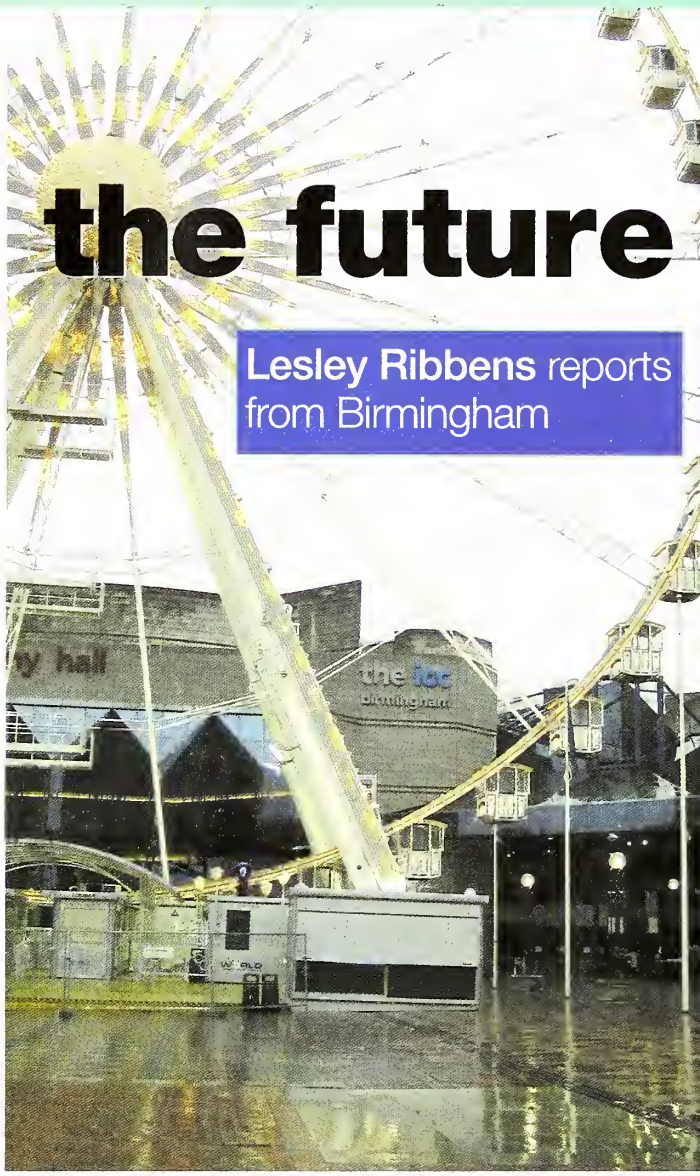
The Big Conversation is Tony Blair's latest attempt at involving the public in developing policy. The internet allows this vast consultative document to be read as separate chapters and appropriate responses made. However, the question is not whether responses are received but whether the Government will listen.

I have downloaded the chapter on *How do we lead healthier lives* and I have read the brave words. I could make many general suggestions and many, specific to how I as a community pharmacist could enable Tony's dream to become that little more of a reality. But I also know that what I say, along with similar comments from my colleagues and representative bodies, has been said already and nobody, least of all the Prime Minister, appears to be listening.

Cynics might say this exercise in public consultation is one giant public relations stunt. British governments all assume they enjoy total delegated responsibility. They make executive decisions on our behalf then send them to Parliament for endorsement. True consultation should involve an executive suggestion that reflects the majority view and is put to a referendum for a binding decision. This will not happen to the Big Conversation. Tony Blair already knows the majority opinion of the pharmaceutical profession and for ideological reasons he chooses to ignore it. I remain a cynic.

Report PSNC Conference

Examining the future



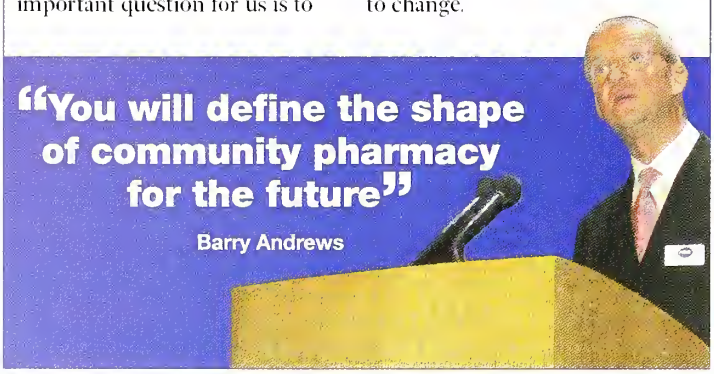
Lesley Ribbens reports from Birmingham

With the re-negotiation of the core contract, community pharmaey faces the most fundamental challenge it has seen in the past 60 years, chairman Barry Andrews told the sixth annual PSNC Community Pharmacy conference in Birmingham last week. "The future role and function of community pharmacy is being fundamentally re-examined and redefined."

The new GMS contract, he said, is not just a GP contract. Many services will be provided by people other than GPs. "One important question for us is to explore how it may affeet community pharmacy services."

There are unprecedented opportunities for pharmacists but there are risks too with community pharmacy's role uncertain. "You will define the shape of community pharmacy for the future," Mr Andrews told contractors.

The result of the PSNC's ballot on the new contract – 95 per cent in favour of the new contractual framework – was "an unpreeedented result", said Mr Andrews, and it demonstrated that pharmacists are not averse to change.



April target for contract framework

The new contract will not be in place by April 2004, but there will be agreement "in terms of the detailed specifieation and funding", predicts Steve Williams, chairman of PSNC's contract planning committee.

A phased introduction is likely, with most essential services provided within year one but funding discussions are not sufficiently progressed to confirm timings.

PSNC is committed to a full consultation on the new contract and there will be a full second ballot of all contractors, stressed Mr Williams, but whether that will be before or after April 2004 he would not say.

Talks between PSNC, the DoH and NHS Confederation continue to be constructive, he claimed. PSNC's main aim is to ensure that the core element of the service is based around a supply function so community pharmacy remains the logical base for primary care. But government policy dictates that there must be changes to delivery.

The new framework will be built on present experienee and serviees, many of whieh are not recognised by the NHS. "The integration of community pharmacy into primary care is a erucial driver for all parties in the new contract negotiations," said Mr Williams. "But we need to be realistic about drivers for change and funding," he cautioned.

Essential services that must be provided by all contractors will inelude dispensing, repeat dispensing, elinical governance, signposting to other healthcare professionals, waste collection and public health. Detailed specifications and audit measures for each of these are being developed, together with costings.

Enhanced services, which require accreditation of pharmacist and premises, include medicines use review on a timetabled rather than ad hoc basis, and prescribing interventions. Additional services, which are commissioned locally but speeified and valued nationally, include: EHC, smoking cessation, warfarin clinics and collection and delivery. Many of these are currently provided by pharmacists but not recognised by the NHS. These will be paid for through the PPA.

The environment must be right for the introduction of the new contract, said Mr Williams. The PSNC is pushing for a pharmaceutical needs assessment to be conducted by each PCT so that contractors can provide services that the PCT wants and that the local population needs.

"LPCs have a critical role in working with PCTs ... so they are aware of the services that community pharmacy ean and should provide." The GMS contract offers many drivers to indicate how community pharmacy services will be provided in the future.

Fair funding is the other key issue in the new contract. PSNC wants "a well-researehed, thorough, evidence-based approach to negotiating fair funding and that starts with the cost enquiry", said Mr Williams. Data currently being collected in the cost enquiry will form the basis of all funding arrangements made in future.

PSNC has produeed models to calculate the cost of any new service. "Discussions on funding are, and will be, difficult," admitted Mr Williams. Talks on how money from the global sum will be distributed have yet to start.

All parties aeknowledge that the new contract cannot be delivered without proper IT links to the rest of the NHS and to GPs in particular. "We ean expect aceess to the integrated patient record and this will allow us to deliver services in the way we want," said Mr Williams. But there are cost implications which will be included in talks about funding.

Continued on page 18 ▶

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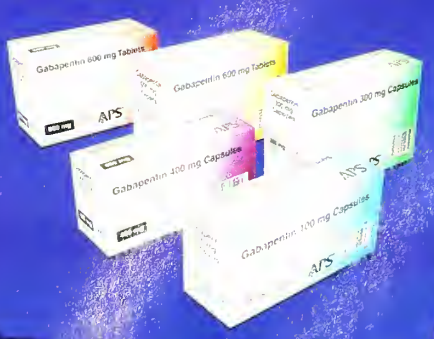

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ME OF THE MEDICINAL PRODUCT Gabapentin 100mg Capsules, Gabapentin 300mg Capsules, Gabapentin 400mg Capsules, apentin 600mg Tablets, Gabapentin 800mg Tablets. THERAPEUTIC INDICATIONS As adjunctive treatment for partial epilepsy with vithout secondary generalised seizures in patients refractory to standard antiepileptics. Symptomatic treatment of postherpetic ralgia. DOSAGE The dosage regimens for this product vary according to the indication and patient. Please refer to Summary of duct Characteristics. CONTRA-INDICATIONS Hypersensitivity to gabapentin or to any of the excipients. SPECIAL WARNINGS AND CAUTIONS FOR USE Gabapentin should be used with caution in patients with mixed seizures including absences. Gabapentin is recommended for use in children (under the age of 12 years). Abrupt withdrawal may increase the risk of an increased number eizures or even precipitate status epilepticus. Caution is recommended in patients with a history of psychotic illness. The film-ed tablets contain soybean oil (as source of hydrogenated vegetable oil) which may rarely cause allergic reactions. RACTIONS It is recommended that gabapentin is taken about two hours after any administration of antacid. UNDESIRABLE CTS Common: Somnolence, drowsiness, fatigue, dizziness, headache, insomnia, weight gain, anorexia, peripheral or generalised ema, increased appetite. Ataxia, nystagmus, tremor, amnesia, speech disturbances, paraesthesia, twitches, amplified, alleviated or absent reflexes, abnormal thinking. Dyspepsia, nausea and/or vomiting, diarrhoea, dry mouth, constipation, abdominal pain, dental abnormalities, gingivitis. Nervousness, depressive mood, disorientation, emotional lability. Diplopia, visual disturbance. Vasodilatation, hypertension. Rhinitis, pharyngitis, cough. Incontinence. Impotence. Uncommon: Peripheral oedema. Leucopenia. Pruritus. Confusion, hypesthia. Depression, psychoses/hallucinations, hostility. Blood glucose fluctuations. Dyspnoea. Very rare: Allergic reactions (Stevens-Johnson syndrome and erythema multiforme). Haemorrhagic pancreatitis, hypotension, bradycardia, syncope, atrial fibrillation, electrocardiographic abnormalities and maculopapular rashes have been reported in patients receiving Gabapentin. MARKETING AUTHORISATION HOLDER Approved Prescription Services Ltd. MARKETING AUTHORISATION NUMBERS 00289/0590 (Gabapentin 100mg Capsules), 00289/0591 (Gabapentin 300mg Capsules), 00289/0592 (Gabapentin 400mg Capsules), 00289/0593 (Gabapentin 600mg Tablets), 00289/0549 (Gabapentin 800mg Tablets). LEGAL CLASSIFICATION Prescription Only Medicine (POM) PRICE Gabapentin 100mg Capsules £20.57, Gabapentin 300mg Capsules £47.70, Gabapentin 400mg Capsules £55.20, Gabapentin 600mg Tablets £95.40, Gabapentin 800mg Tablets £110.39. DATE OF PREPARATION August 2003.

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Report PSNC Conference

Funding equation still unclear

The overall funding for the new contract is an equation. The principle is agreed with the DoH, but the costs are not, so it is not yet known whether the equation balances, said PSNC financial executive Godfrey Horridge.

The total payment due is the cost of providing the contract plus a fair return. This is met by the global sum plus purchasing incentives. Whether the global sum will be capped is not known.

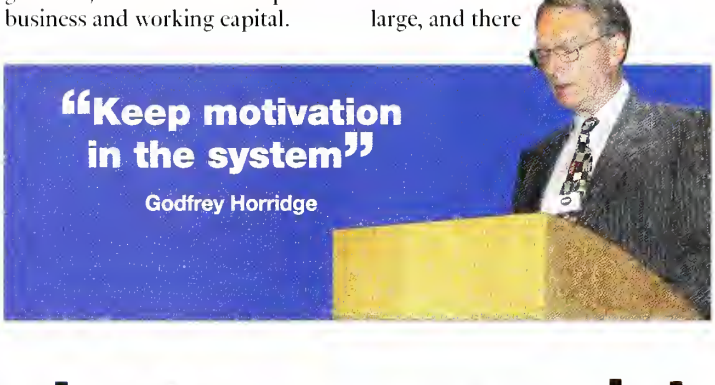
The cost of providing the new contract is being calculated from figures provided by a contractor survey. Of the 470 contractors approached, just over 300 responded, providing details in the four key areas of staff costs, premises costs, local overheads and, for those in a group, head office overheads. The data is currently being validated and, once agreed, will become the basis for the new contract.

A spreadsheet model is under development to cover essential and enhanced services. A detailed specification will be used for each service and extra costs will be calculated under the four key areas above. It will incorporate gradual take-up and be dynamic enough to cope with service and cost changes.

In addition to costs, a model has been developed to give a fair return on the capital invested. Two aspects are considered: the cost of the capital invested and economic profit. Capital invested includes goodwill, fixed assets tied up in the business and working capital.

Mr Horridge said there are concerns over the variability of local funding, so PSNC wants cost plus a fair return to be met nationally. Additional services will be agreed nationally but commissioned locally. Profit on purchasing is not known at the moment and a pilot is underway with the DoH looking at information from 109 contractors.

Mr Horridge's view is that the global sum element is too small and the purchasing element too large, and there will need to be some rebalancing.



Payments need to be simple and sensible, and "keep motivation in the system". Payments need to be front-loaded so that access is not compromised, and should reward quality and volume, meet costs and give a fair return for all, he said.

The elements of payment are undecided but will certainly include a dispensing fee per item but whether this is single or tiered is unclear. On allowances, the 1,100-item threshold seems to make sense although this issue hasn't been debated. Graduation is likely but a single professional allowance is unlikely. Quality points, as used for GPs, are still a possibility. The accreditation scheme is leaning towards a national set-up but is not finalised.

The expensive prescription fee is likely to continue and the Essential Small Pharmacy Scheme is certain to, although it may be "tweaked", said Mr Horridge.

GMS contract means more scripts

The new GMS contract will mean more prescriptions, according to Chris Town, chief executive officer of Greater Peterborough Primary Care Partnership. Only 25 per cent of people with chronic diseases are treated properly, so there is a need to identify these patients and to treat them, and to improve their medicines management, he explained.

GPs will want to get the most out of their contract, as will PCTs. There are a number of drivers for community pharmacy. While GPs may have thought that enhanced services would go to general practice, there is no reason why community pharmacy could not tender for some services, he said.

The expectation is that not just GPs will be in partnership soon. Mr Town predicted new partnerships will emerge in the future and new businesses develop.

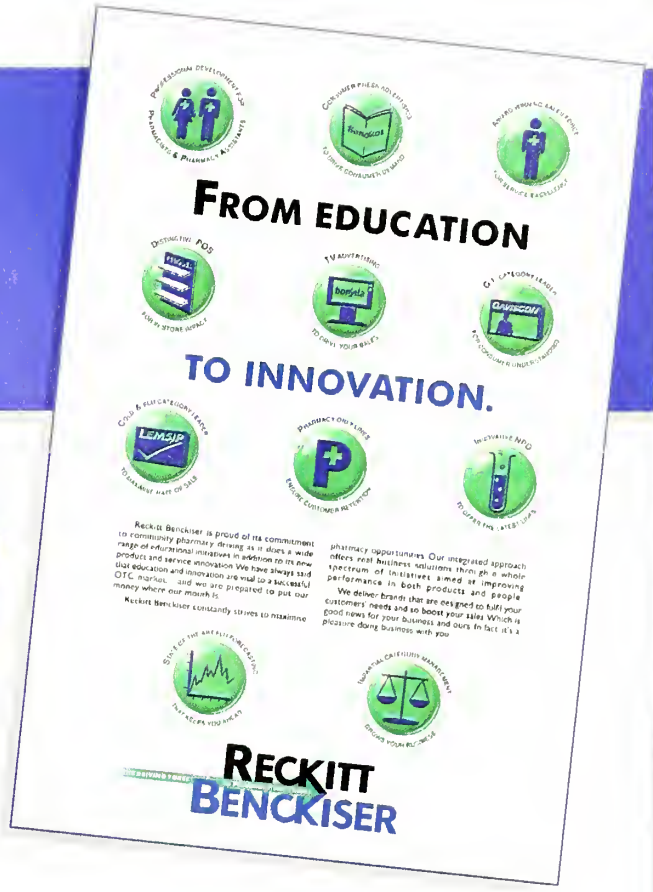
The out-of-hours changes will have an impact on community pharmacy. The new arrangements present real opportunities for pharmacies to work with PCTs. There is a need for services in the evenings and at weekends, particularly in commuter areas.

"We're not trying to dream up wild, wacky things for pharmacists to do," said Mr Town. "We hope that if we get the framework and infrastructure right, the sector will move on and expand significantly."

Pharmacists will start supplementary prescribing and move towards more independent prescribing, and via regulatory changes a greater range of OTC medicines will be available through pharmacy, suggested Mr Town. In Peterborough, 16 community pharmacists have been recruited to work part-time on the PCT to develop formularies.

Chronic disease is not managed well and there are huge benefits to improving this through disease management clinics. There will be a move towards dealing with this in the community, ideally in the pharmacy, and this will be built into the new contract. Around IT there are big opportunities. Links with community pharmacy have not been made but there is a genuine commitment to connect it to NHSnet. Investment is needed but the timing is unclear.

REMEMBER WHAT WE SAID?



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EMA Awards

GI Category

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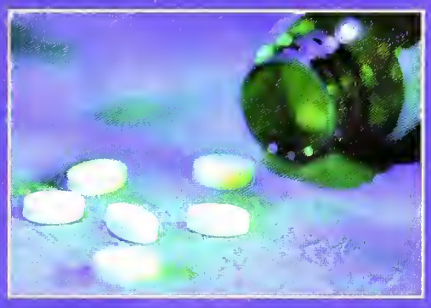

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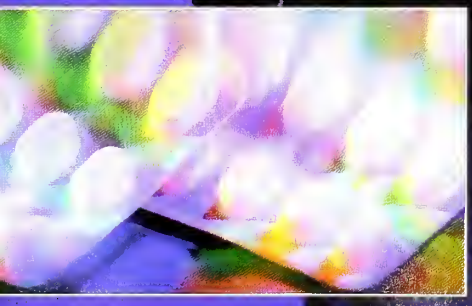

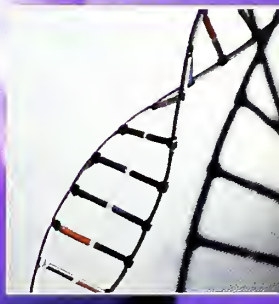

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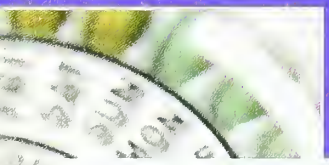

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In this second article on HIV treatments, *Elizabeth Davies* and *Victoria Latham*, Chelsea and Westminster Hospital, suggest ways in which community pharmacists may contribute to the care of these patients

Life with antiretrovirals

THE COLLEGE OF PHARMACY PRACTICE
This course (module 1289), in association with multiple choice questions being published in C&D January 3, provides one hour's continuing education

- To be aware of antiretroviral drug side effects
- To understand the basic principles of treatment
- To be aware of current guidelines on treatment
- To understand therapy changes for virological failure
- To be aware of the infections that put HIV patients at risk

Last week (*C&D, November29, p21-23*) we outlined the main properties of drugs available to treat HIV. In this article we look at the prescribing of these drugs in practice, based on the current UK guidelines for treatment, and how pharmacists might advise on alleviating side effects.

There are numerous issues on which HIV infected patients might consult a community pharmacist, particularly minor ailments that might be side effects of drug therapy. Patients can manage many of these, given appropriate advice. In all cases, patients should never be advised to discontinue their HIV treatment without first discussing it with their HIV physician.

Patients should never be advised to discontinue their HIV treatment without discussing it with their HIV physician

Nausea and vomiting

Zidovudine, didanosine and the protease inhibitors all tend to cause nausea in the first few weeks of therapy but in most cases this ceases by three weeks.

Additionally many patients are treated for depression with SSRI antidepressants, which cause nausea in the first month. With the exception of didanosine (this must be taken on an empty stomach), taking the dose with or after food reduces, and often prevents, nausea.

If nausea is still a problem, then an anti-emetic 20 minutes before the problem drug should help; often patients will have been given these when they start combination therapy to use on an 'as required' basis. If not, domperidone is a suitable anti-emetic to recommend.

Diarrhoea

About 60 per cent of people with HIV-related illness experience some degree of diarrhoea or bowel dysfunction. It can be a side effect of drug treatment or the result of opportunistic infection. Protease inhibitors commonly cause diarrhoea in the first weeks of treatment, and in some patients this persists long term. It is treated symptomatically with antidiarrhoeals, usually loperamide, then if no response opioids, typically codeine. It is not unheard of for patients regularly to take 16mg or more loperamide daily.

Nelfinavir-induced diarrhoea responds particularly well to calcium supplements, such as Calcichew 500mg, twice daily. Diarrhoea that seems to be unrelated to a change of therapy always warrants investigation, as it may well be infective in nature.

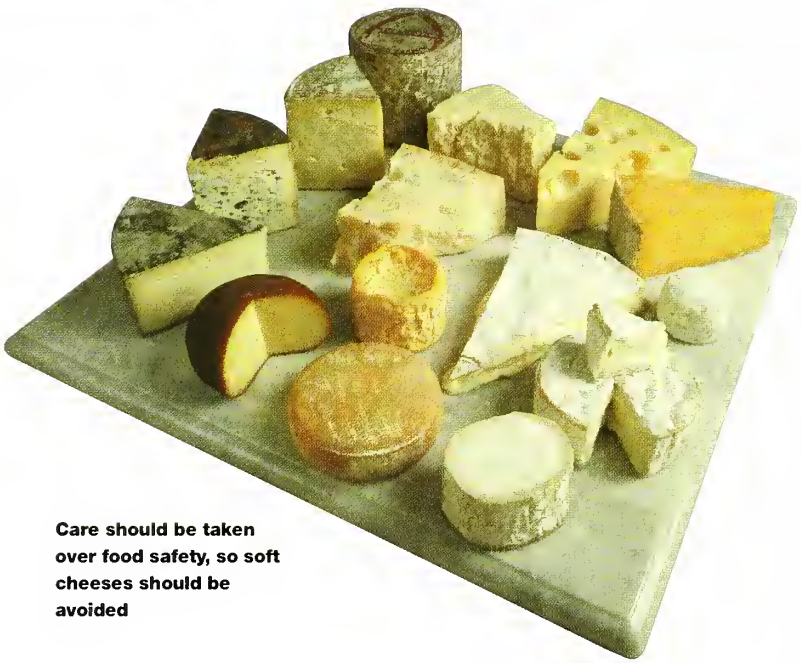
Acute diarrhoea is commonly due to *salmonella*, *shigella* and *campylobacter* among others, and is treated with antibiotics. Chronic diarrhoea can be caused by *cryptosporidia* or *microsporidia*, which do not respond well to antibiotic treatment, or by treatable infections such as cytomegalovirus (CMV) or *mycobacterium avium* complex (MAC).

Fluid losses of three litres daily are not uncommon in some of these infections, which result in weight loss, dehydration and electrolyte imbalances. Patients should be encouraged to drink plenty and may benefit from rehydration drinks. HIV-positive

Continued on page 22

people are particularly prone to water and food-borne infections and those with CD4 lymphoeyte eounts below 200 cells/mm^3 need to take particular care about food safety, as per usual guidelines, such as avoiding (uncooked) soft ripened cheeses.

Cryptosporidial infection can be contraeted through contact with stools of infeeted animals or people. Extra eare should be taken with pet litter trays, changing nappies, soil and washing raw salad items. All water (bottled and tap) is a potential source of *cryptosporidium* infection and the oocysts can be removed only by boiling for one minute (boiling a kettle is NOT adequate) or by filtering water through a filter with a mesh size of less than one micron. Freestanding water filters are insufficient to remove *cryptosporidia* but suitable filters ean be fitted to the fresh water supply.



Care should be taken over food safety, so soft cheeses should be avoided

Dizziness

Efavirenz typically causes dizziness for the first weeks of therapy and in most eases resolves by three weeks; for this reason it is often recommended that efavirenz is taken at bedtime. If there are ongoing problems, then this effect can be ameliorated by taking efavirenz on an empty stomach (meals with a high fat content have been shown to increase the absorption of efavirenz, whieh may result in increased side effects).

Sleep disturbance

Some 50 per cent of patients report some kind of sleep disturbance with efavirenz, typically vivid dreams but also insomnia, "hangover" effect, nightmares and even hallucinations. These problems ean be reduced by taking the dose on an empty stomaeh, which reduces absorption, or by changing the time of the dose to earlier in the day. (However, timing of antiretrovirals should be changed only in diseussion with the patient's HIV doctor or pharmacist). Haloperidol, at a low dose of 1.5mg - 3mg, is commonly used to alleviate sleep disturbances.

Stavudine, didanosine, and zalcitabine can all cause peripheral neuropathy, as indeed can HIV itself. Presenting symptoms include pain, a burning sensation or tingling in the fingers or toes. Gradually over time this worsens and spreads up the limbs. The changes are irreversible but symptoms are managed with analgesia; gabapentin, tricyclic antidepressants and opioids may all be helpful. Antiretroviral therapy is changed or doses altered depending on the severity of symptoms and HIV disease.

Generalised, non-specific pain in HIV disease is difficult to treat, usually because the cause is unknown and may be associated with underlying depression. Patients presenting with pain can safely be reeommended over the counter analgesic preparations – there are no significant interactions with currently available antiretrovirals – but should also be advised to see their GP or HIV elinie doctor if there is doubt as to the cause of the pain.

Taste changes

These are usually temporary and may be caused by infection, such as overgrowth of oral *candida* or by drugs, particularly those used in chemotherapy such as eyclophosphamide or cisplatin, whieh can cause a metallie taste.

Altering flavours, textures and temperatures of food ean make it more palatable at sueh times; patients can get advice about this from their elinic dietieian. A mouthwash may help, as will regular brushing of teeth. Many of the liquid preparations of antiretroviral drugs taste bitter and having them with chocolate, milk or a spoonful of peanut butter ean help.

Principles of therapy

If we go back to basics, the stage of HIV infection can largely be measured and determined by two surrogate markers – the CD4 lymphocyte count and the viral load, that is, the number of RNA viral particles per ml of plasma. This is usually referred to as the number of copies per ml. In a normal healthy individual the usual CD4 count is in the region 450-1,660 cells/mm^3. Viral replication in CD4 cells causes cell death, so the higher the viral load, the faster the CD4 cell count declines. As the CD4 count declines the immune system becomes compromised, leading to the risk of opportunistic infections and eventually death.

The aim of antiretroviral therapy is to reduce the viral load to as low a level as possible, by preventing viral replication, thereby improving the immune system, quality of life and life expectancy. At present it is not possible to eradicate HIV completely, therefore the general aim of treatment is to reduce the viral load to the lowest possible level, which in practice is the level of detection of the available assay. Current assays can detect down to 50 copies per ml, therefore an individual is referred to as having an "undetectable viral load" if their viral load result (VL) is below 50 copies per ml.

Resistance rapidly develops to antiretroviral drugs if they are not used in combination. Effective combination therapy or "highly active antiretroviral therapy", often termed HAART for short, is now the standard of care for HIV infected individuals requiring treatment in the developed world. HAART means treatment with at least three antiretroviral drugs to which the virus is sensitive.

Adherence to HAART is vital for it to be successful. It has been shown that even at 95 per cent adherence levels there are some patients who will not aehieve an undetectable plasma viral load. As each class of antiretroviral currently available exhibits 'within class' cross resistance, development of resistance to a drug sometimes means resistance to that entire class of drugs, thus limiting future treatment options.

It is fair to say that HIV is no longer considered the terminal illness it was five to 10 years ago, but more a chronic infection, manageable with antiviral therapy. However, it is presently considered necessary for therapy to be life long and, as in other disease states, long-term adherence is a real obstacle for many patients.

The *2003 British HIV Association Guidelines for the Treatment of HIV Infection* can be found on the website *www.bhiva.org*.

Please refer to the website for further detail. We will concentrate on the following aspects:

When to start treatment
What to start treatment with
When to change treatment
What to change to

When to start treatment

The simple answer is - start treatment before the immune system is irreversibly damaged. Once the CD4 lymphoeyte count falls below 200 cells/mm^3 an individual is then at risk of developing serious opportunistic infeetions, such as *pneumocystis carinii* pneumonia, in addition to chronie infections that greatly affect quality of life, such as oesophageal *candida*.

Antiretroviral therapy should be initiated when the CD4 count is between 200 and 350 cells/mm^3, and the exact timing should depend on individual factors such as symptoms, patient preference, likely adherenee and potential toxicity.

Severely symptomatic disease is unusual at CD4 counts above 350 cells/mm^3 in chronic HIV infection, but provides a rationale for treatment when it occurs.

Continued on page 24 ▶

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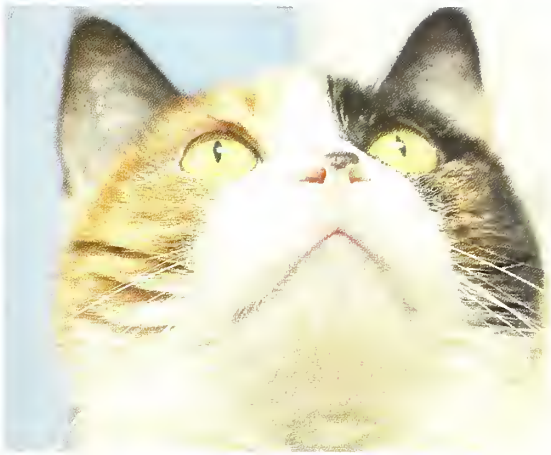
What treatment to start with
Please refer to the article (*C&D last week, p21*) for a comprehensive list of the available drugs. There is more evidence and experience available to support initial regimens that include two nucleoside analogue reverse transcriptase inhibitors (NRTIs) plus either a protease inhibitor (PI) or a non-nucleoside reverse transcriptase inhibitor (NNRTI) than for other combinations, so treatment should be initiated using one of these regimens.

Examples of such regimens are Combivir + efavirenz (NNRTI) or Combivir + Kaletra (PI). If a protease inhibitor regimen is chosen it is now generally considered optimal to use a PI boosted with low dose ritonavir (one capsule twice daily) to improve the pharmacokinetics and reduce the pill burden, rather than to use an unboosted PI. For example, Kaletra is a co-formulated preparation containing lopinavir 300mg and ritonavir 100mg when taken at its usual recommend dose. Combination therapy including stavudine (d4T) is no longer recommended for initial therapy because of possible risks of more rapid development of lipodystrophy.

When to switch therapy for virological failure
Viral load measurements are routinely performed about every three months. If on two consecutive occasions the VL result returns as being >400 copies per ml, and there are other treatment options available to the patient which could optimally suppress viral replication, treatment should be changed.

However, it is important to remember factors – other than drug resistance – that could induce therapeutic failure, such as poor adherence or enzyme-inducing drugs. In cases where it is unlikely that further treatment will produce complete inhibition of viral replication, continuation of current therapy is reasonable if the imminent risk of death is low, judged by the CD4 count.



Cryptospordial infection can be contracted through contact with stools of infected animals or people. Extra care should be taken with pet litter trays

Washing raw salads with water is risky because of cryptosporidium

Which drugs to use following failure of initial therapy
Wherever possible one or two different drugs of the NRTI/PI/NNRTI classes should be included in the second regimen. Clearly, choice of a second line regimen depends ultimately on what drugs were prescribed in the initial regimen. Because there is cross resistance within drugs from the same class, resistance testing should be used to guide the choice of subsequent therapy.

Patients whose therapy fails because of problems with adherence may benefit from simpler regimens to which their virus is still sensitive, for example a regimen that can be taken once daily. However, adherence issues must be addressed before any changes to the combination are made. Most clinics have adherence sessions run by pharmacists, nurses or health advisers, which address the myriad lifestyle and health belief factors affecting an individual's adherence.

In addition, adherence should be discussed with all patients at each visit, as it has been consistently shown that continued intervention is necessary in chronic disease to maintain high concordance.

The further down the treatment line you go, the more complicated it becomes, and the expertise of experienced HIV physicians and virologists is needed to build suitable and effective regimens.

Other factors complicating treatment choices are co-morbid conditions such as hepatitis B and C, and pregnancy, and the treatment of HIV infected children is a specialist area in itself.

Some individuals with longstanding HIV infection who are heavily pre-treated are in the impossible situation of having no treatment options remaining to which their virus is sensitive. We can only hope that new effective therapies become available in the near future.

Although the complex nature of antiretroviral therapy necessitates that HIV patients are managed within secondary care, the diversity of problems encountered with antiretroviral therapy means that patients often do not associate problems with their therapy and seek help in primary care.

Community pharmacists are well placed to respond to this need and hopefully these two articles have provided the basic building blocks of HIV therapy, as well as practical advice on managing side effects. As a final note, most patients will have the telephone number of their HIV pharmacy or clinic, from whom advice can always be sought.

Elizabeth Davies is principal pharmacist HIV/GUM and Victoria Latham clinical pharmacist HIV/GUM at Chelsea and Westminster Hospital, London.

Actionplan

1. Many of the drugs for HIV treatment are used in combination. Why is this so? Are there advantages in this approach to therapy? List in your practice workbook other disease states that use this combined drug approach.
2. Compliance and adherence are major problems in HIV treatment. Think how you can apply concordance to improve this. Note any strategies you could use.
3. It is unlikely you will know which patients presenting with the side effects of HIV drugs are actually taking such a drug. Think about this problem. How will you establish that the problem presented is drug induced?
4. The article emphasises side effects of HIV-related drugs. List in your practice workbook the advice you would give to patients taking such drugs so that they could live with these problems.
5. HIV patients are at risk from opportunistic pathogens. In your practice workbook list any source of such organisms and your avoidance advice.

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice questions (MCQ) paper to be inserted in the January 3 issue, which will cover this week's CPP-accredited module. Answers to that in the December 13 issue. These will cover:

- **HIV treatments part 2 (1289)**
- **Alcoholism (1290)**

The C&D marking service offers independent verification of results – details on the monthly MCQ papers. Those wishing to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

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Echinacea is not effective in children, claim researchers

Echinacea is not effective for treating children's colds, claim researchers in the USA, but manufacturers are disputing the scientists' claims.

Over 500 children were included in the study and were randomly given either placebo or *Echinacea purpurea*. Both treatments were started at the onset of the child's symptoms for a maximum of 10 days.

Of the 524 children in the study, 407 experienced at least one upper respiratory tract infection. The median length of the children's colds was nine days. The researchers found that there was no statistically significant difference between the severity and length of colds in the placebo and echinacea groups.

The rate of adverse event reporting was similar for echinacea and placebo, but the rash was more common in

Echinacea was no better than placebo for children's colds

children taking echinacea (7.1 per cent) than those on placebo (2.7 per cent).

The authors said: "Given its lack of documented efficacy and an increased risk for the development of rash, our results do not support the use of echinacea for treatment of URIs (upper respiratory tract infections in children aged between two and 11. Further studies using different echinacea formulations, doses and dosing frequencies are

needed to delineate any possible role for this herb in treating colds in young patients."

Simon Mills, chairman of the British Herbal Medicine Association, said: "The study is an impressive investigation of the effect of *Echinacea purpurea* on the incidence of upper respiratory tract infections in childhood. The lack of any noticeable effect is clearly disappointing." He queried the appropriateness of dosage and preparation, but concluded: "It may be that the value of echinacea needs further exploration."

Bioforce said that its products use extracts of the aerial and root parts of *Echinacea purpurea*, rather than the pressed juice in the trial, which it says an earlier trial of which generated negative data. The company said it is aware of positive clinical trial data to support echinacea use in colds. Although these trials do not include children, experience indicates, it said, that they respond well to echinacea products.

Pfizer was unable to comment, but pointed to a trial using the pressed juice, which it said showed echinacea's effect on reducing a cold's duration.

For more information:

JAMA 2003; 290: 2824-30.

Aspirin & NSAIDs fine for post-MI

Aspirin's cardioprotective effects for post-MI patients are not diminished by concomitant ibuprofen prescribing, claims a study in the USA.

The study, which followed over 230,000 post-MI patients, found that there was no difference in the mortality rates of patients who received aspirin alone or those who took aspirin and ibuprofen or another NSAID.

The authors of the study, published in the *BMJ*, said that their results differ from earlier studies because the size of the cohort in the original study was too small (187 patients).

The patients were all over 65 years old with established cardiovascular disease. The authors admitted that they could not account for ibuprofen and other NSAIDs bought over the counter, but concluded that claims for patients to avoid other NSAIDs when taking aspirin appear to be unfounded.

For more information:

BMJ 2003: 327.

Vitamin B_{12} helps depression

Vitamin B supplements could be beneficial to people with depression, claim researchers in Finland. The news has been welcomed by a depression charity.

The study found that patients with higher levels of vitamin B_{12} in their blood responded better to their depression medication than those with lower vitamin levels.

"As far as we know, there have been no previous studies that have suggested a positive relationship between vitamin B_{12} and the treatment outcome in patients with major depressive disorder who have normal or high vitamin B_{12} levels," said the authors in *BMC Psychiatry*.

A spokeswoman for the Depression Alliance said:

Vitamin B_{12} supplements could enhance depression treatments

"Including B vitamin supplements into a person's diet is a very simple thing to do and if it positively affects the outcomes of a conventional treatment programme, it should be implemented as part of the standard package offered by the GP. Depression Alliance believes that a holistic package of care, including nutritional advice, is usually the best approach to treat depression."

For more information:

BMC Psychiatry 2003; 3:17.

Older BP drugs as good as each other

Blood pressure control is similar in hypertensive patients taking beta-blockers or calcium-antagonists, and neither group is at greater risk of further cardiac events, say researchers in the USA.

The INVEST trial looked at 22,576 hypertensive patients with coronary artery disease aged 50 or older. Patients were randomised to either verapamil SR or atenolol. Trandolapril and/or hydrochlorothiazide were added if blood pressure goals were not reached. Trandolapril was also recommended for patients with heart failure, diabetes or renal insufficiency.

The authors suggest that drug therapies for coronary artery disease patients can be based on factors such as history of heart failure, diabetes risk and adverse experiences, with no concern that one regime is inferior to another. Both strategies were equivalent in preventing all-cause mortality, non-fatal MI and non-fatal stroke, as well as blood pressure control.

For more information:

JAMA 2003; 290: 2805-16.

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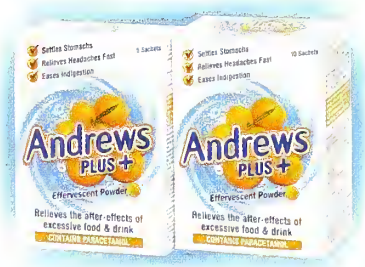
Frontshop

Andrews extra Christmas fizz

The Andrews brand is being extended in time for the festive season with Andrews Plus+ effervescent powder.

Sugar-free Andrews Plus + is formulated to settle the stomach, relieve headaches and ease indigestion.

Ingredients include paracetamol and vitamin C and the powder has a pleasant orange flavour.



The eye-catching pack features oranges against a new swirl and bubble effect designed to portray refreshing effervescence.

The launch will be supported by a £400,000 national press and radio campaign timed to ensure high profile coverage during the festive season.

The product is available in single-dose sachets of five and 10.

Price: 5s £2.19, 10s £3.49

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GlaxoSmithKline Consumer Healthcare

Tel: 0845 762 6637.

'What a Performance' from Centrum multivitamins

Centrum Performance will be in the public eye during December and January backed by a £1.7 million advertising burst.

Two new commercials for the multivitamin product will be on air from December 27 and a new radio campaign has started this month.

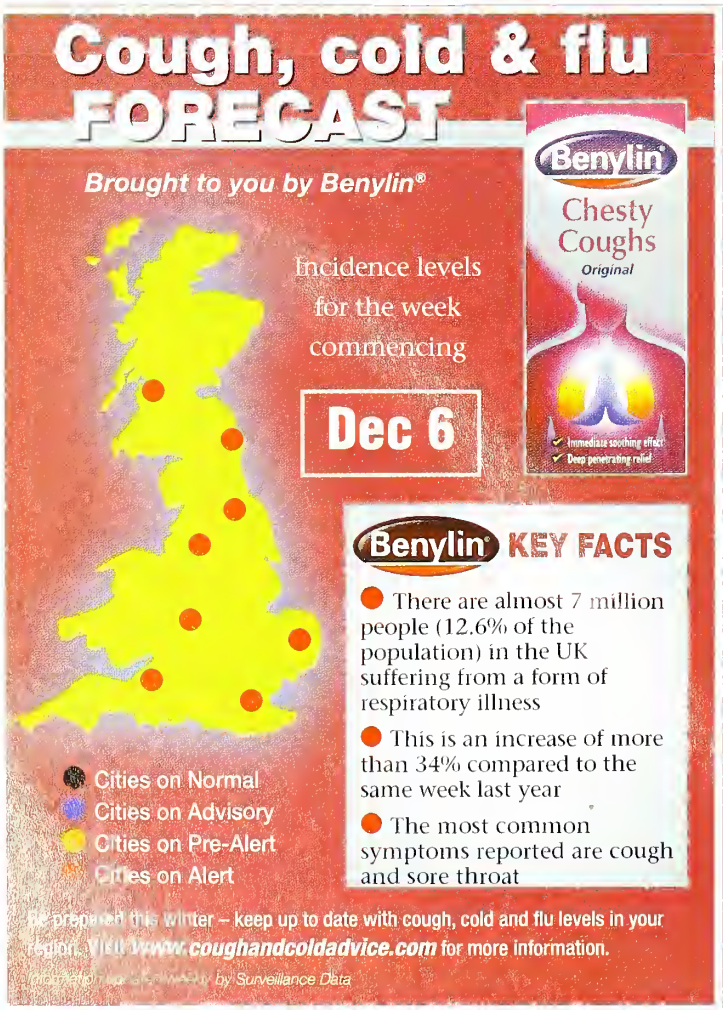
The advertising storylines show people in ordinary situations doing unusual things, with the message 'What a Performance'.

In addition, Centrum sponsorship of 'Good Morning Sports Fans' on Sky has been extended until April and now focuses on Centrum Performance.

For more information:

Wyeth Consumer Healthcare

Tel: 01628 669011.



Scriptlines

Generic gabapentin

APS/Berk has launched the first generic gabapentin indicated for epilepsy and neuropathic pain.

Gabapentin is available in 100mg, 300mg, 400mg capsules, 600mg and 800mg tablets, all in packs of 100.

For more information:

100mg £20.57	110-8166,
300mg £47.70	110-8174,
400mg £55.20	110-8182,
600mg £95.40	110-8190,
800mg £110.39	110-8208

APS/Berk

Tel: 0800 590502.

Humulin packaging

Lilly has brought its insulin products' packaging in line with the International Diabetes Federation's standards.

Each formulation of insulin will have a dominant colour, regardless of manufacturing company. In addition, Lilly's products will all carry blue as a secondary colour. The company has also introduced Braille onto its Humulin packaging.

The company expects that stocks will be available in mid-December.

Novo Nordisk and Aventis have already changed their packaging in line with the IDF's standards.

For more information:

Lilly, Medical Information

Tel: 01256 315999.

Zyprexa BD licence

Zyprexa (olanzapine) has been granted a licence by the Medicines and Healthcare products Regulatory Agency for the prevention of recurrence of bipolar disorder in individuals who have successfully treated their manic episode with Zyprexa.

Eli Lilly claims that Zyprexa is the first treatment in the UK to be approved for preventing symptoms recurrence in bipolar disorder since lithium. Its research showed that patients taking Zyprexa were less likely to experience a mania or depression relapse when compared with placebo.

For more information:

Eli Lilly

Tel: 01256 315000.

Aerocrom discontinued

Castlemead is discontinuing Aerocrom inhaler (sodium cromoglycate 1mg, salbutamol sulphate 100mcg) and Aerocrom Syncroner (sodium cromoglycate 1mg, salbutamol sulphate 100mcg).

The company expects that stocks will be exhausted in February 2004. It warns that any outstanding orders still held when Distriphar's stocks are exhausted will be cancelled.

For more information:

Distriphar

Tel: 0870 5133347.

Frontshop

Throwaway thermometers have family appeal

InfoHealth is launching a range of easy-to-use, mercury-free disposable thermometers.

EZEtemp is an oral or underarm thermometer for adults and children. The thin, flexible plastic strip is designed as a disposable, single-use or multiple-use thermometer.

TraxIt is a wearable adhesive underarm thermometer for infants and children. The heart-shaped sticker provides accurate readings for up to 48 hours.

The first reading is available two to three minutes after the thermometer is applied. The temperature can then be read as often as required, even while the child is asleep.

Both thermometers use continuous-reading Precision Phase Change technology to give accurate temperature readings. The dot-matrix grid provides easy-to-read dot pattern-values.

The thermometers are hypo-allergenic and with no shared use, there is no risk of cross-infection.

The launch will be supported by a £500,000 advertising campaign in the Bounty pack and parenting press from the New Year until the spring.

Point of sale and window display material is available for pharmacies.

Price: EZEtemp 12s £3.79, TraxIT 4s £3.89, 8s £5.89

Pip code: EZEtemp 300-5253, TraxIT 4s 300-5261, TraxIT 8s 300-5279
InfoHealth Distribution Ltd
Tel: 0208 763 9675.

Babyfood planning service goes online

Heinz has launched a joint online initiative for pharmacies in conjunction with space planning consultant Shelfmax.

Pharmacists can log on to the Shelfmax website to receive babyfood merchandising plans that are tailored to their individual needs.

The free service is simple to use and enables pharmacists to prepare online core range planograms for the exact dimension of their fixtures. The plans are based on latest independent market data.

Stuart Burns, merchandising project manager for Heinz, says: "We recognise that where babyfood is concerned, one of the key points of difference within pharmacy is the pharmacist's ability to offer advice to new mums.

This tool ultimately enables pharmacists to meet these needs and thereby to build traffic and add value to the sector within their stores."

During a recent Shelfmax trial with a 12-unit pharmacy group, babyfood volumes rose by 26 per cent and the value of the category rose by 19 per cent.

For more information:

www.shelfmax.co.uk

Christmas closures

- Phoenix depots will close on December 25 and 26. Orders taken on the evening of Christmas Eve will be delivered on December 27. All depots will be closed on New Year's Day and Glasgow and Aberdeen will also be closed on January 2.
- Roche drug information customer call desk and consumer health enquiry service will close for enquiries on prescription medicine products from 5pm on December 23 until 9am on January 2. Roche customer services will close from 4pm on December 24 and will re-open for normal service on January 2. A skeleton service will be provided from 9am to 4pm on December 29, 30 and 31. Outside these dates, there will be an emergency only service on 01707 366000.
- Shire Pharmaceuticals will close over the holiday period until January 5 and emergency only cover will be available during this time. Orders must be received before noon on December 18 to ensure delivery before Christmas.
- The Specials Laboratory will close from 1pm on December 24 to 8.30am on December 29 and from 3pm on December 31 until 8.30am on January 2. Fridge lines must be ordered by December 19 for delivery before Christmas and by 10am on December 29 for delivery before the new year.

Frontshop

All clear for Niquitin CQ New Year campaign

NiQuitin CQ Clear patch will be back on TV after Christmas with a £1.6 million campaign to maximise on the New Year quitting season.

The 'clear day' TV commercial communicates the importance of 24-hour protection to fight the nicotine cravings that can strike at any time and undermine the will to stop smoking.

It concentrates on several tricky situations that people trying to give up cigarettes may face in their day, highlighting moments of temptation, with everyday objects transforming into cigarettes.

The campaign will be on air from December 26 until the end of February.

Six 'power postcards' have been produced to support Niquitin CQ 2mg and 4mg Mint Lozenges.

The postcards feature tips to advise people on how to effectively take control of every aspect of their lives to help them stop smoking.

Pharmacies can obtain a free supply of postcards to distribute to customers by calling 0800 358 3060.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 5000.

Listen to Zantac 75

Zantax 75 Dissolve is taking to the airwaves in the run up to Christmas backed by a £330,000 national radio campaign.

Three commercials use wild animals in their native environments to highlight the message that the product is a soluble way to relieve heartburn.

The three-week campaign will be on air from December 8.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637.

Mediterranean delights

Natural Mediterranean is expanding the distribution of its bath and body range in pharmacies.

The Tact Natural Feeling Pure Olive Oil Collection comprises body oil, shampoo, conditioner, foam bath and body lotion. All the products contain Greek virgin olive oil plus other natural ingredients.

A complementary soap collection features nine soaps containing 95 per cent olive oil.

The Tact Natural Feeling Mediterranean Collection includes natural sea salts and co-ordinating soaps in Thyme & Lemon, Chamomile, Mediterranean Sense and Lavender.

Price: from £2.50 for 100g soaps to £7.50 for 500g jar sea salts
Natural Mediterranean Products Ltd
Tel: 020 8451 7121.

TV next week

Benylin: All areas except U
Covonia: B, G, Y, TT, C5, GMTV, Sat
Gavilast: C4, C5, GMTV, Sat
Gaviscon Advance: U, C, HTV, W, LWT, CAR, TT, C4, C5, Sat
Lemsip Cold & Flu Direct Lemon & Blackcurrant: All areas except GTV, B, A, CTV, W, M, TT
Lemsip Max Sinus capsules: All areas except GTV, B, A, CTV, W, M, TT
Meltus: All areas
Nivea Deo Silk: All areas
Nivea Visage Age Reversal cream: All areas
Olbas for children: C5, GMTV
Olbas range: C5, GMTV, Sat
Sensodyne Total Care Extra Fresh: U
Settlers: C5, GMTV
Solpadeine: U
Sudafed Non-Drowsy: All areas except U, GMTV

PharmaSite for next week: Day & Night Nurse – window, **Fluconazole Care Range –** in-store, **Zovirax –** dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

NOW THE FASTEST-GROWING LOZENGE* MAKES HEAVIER SMOKERS' LIVES LESS HELLISH.

The heavy smokers amongst your customers will thank heaven for Nicotinell.

Our new extra strength (2mg) Mint Lozenge for heavy smokers adds to the success of our regular strength (1mg) format for light smokers – the fastest growing lozenge in the market place.

Together with our powerful TV campaign they strengthen your recommendation for a solution that'll give cravings hell.

FOR HEAVIER SMOKERS

nicotine

August 2003

It needn't be hell with Nicotinell®

INELL® MINT 1MG and 2MG LOZENGE **Presentations:** Mint flavoured nicotine lozenge containing 1mg or 2mg nicotine. **Indications:** Treatment of nicotine dependence, as an aid to smoking cessation. **Dosage and nistration:** Stop smoking completely when starting treatment. One lozenge to be sucked when the user feels the urge to smoke. Normally, 8-12 lozenges per day, up to a maximum of 30 pieces of 1mg lozenges per day and 15 s of 2mg lozenges per day. The higher strength is used for those with a strong nicotine dependency. After 3 months, the user should gradually cut down the number of lozenges sucked. *Children and young adults:* To be used in e under 18 years only on medical advice. **Contra-indications:** Non smokers, occasional smokers. As with smoking, Nicotinell is contra-indicated during acute myocardial infarction, unstable or worsening angina pectoris, severe c arrhythmias, recent cerebrovascular accident and known hypersensitivity to any of the excipients. **Precautions:** Hypertension, stable angina pectoris, cerebrovascular disease, occlusive peripheral arterial disease, heart e, hyperthyroidism, diabetes mellitus, renal or hepatic impairment, peptic ulcer, pheochromocytoma. Keep out of the reach of children at all times. **Pregnancy & Lactation:** To be used only on medical advice. **Side Effects:** Events may be related to smoking cessation include headache, sleep disturbances, gastro-intestinal disturbances, and myalgia. May cause throat irritation, hiccuping, minor indigestion or heartburn. **Legal Category:** GSL. **Product Licence No.:** **Price and Suggested Retail Price:** *Nicotinell Mint 1mg Lozenge* PL 0030/0146, available in packs of 12 £1.70, £2.99, packs of 36 £4.27, £7.49 and packs of 96 £9.11, £15.99 *Nicotinell Mint 2mg Lozenge* (PL 0030/0202) in of 12 £1.99, £2.49, packs of 36 £4.95, £8.69 and packs of 96 £10.60, £13.59. **PL Holder:** Novartis Consumer Health, Horsham, RH12 5AB. **Date of Preparation:** August 2003.

Deep Heat goes up in lights

Young sports players and gym users are being targeted with a £1.3 million campaign for the Mentholatum Deep Heat range this winter.

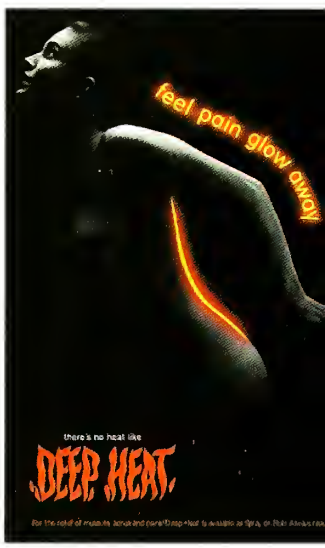
Advertising centres on the brand's first poster campaign in shopping sites, leisure centres and gyms.

The posters, which are backlit, feature striking black and white photographs of naked models with a colour 'glow' tracing the outline of the model's back, shoulder or side.

Featuring the headline 'Feel the pain glow away', the poster campaign will run until the end of January.

Advertising is also appearing in men's health magazines, sporting titles and national newspapers.

Mentholatum's Rohto eyecare products are being offered at £1 off in independent pharmacies until the end of this month.



For more information:
Pharma Consumer Care
Tel: 01202 314824.

Fighting heartburn fast

In preparation for the peak overindulgence season, pharmacy-only Gaviscon Advance will be on TV this month in a £500,000 campaign running throughout the Christmas period and into the start of next year.

The commercial shows a woman who is struck by painful acid heartburn. She reaches for a bottle of Gaviscon Advance which coats and soothes the inside of her burning throat and provides instant relief from the heartburn. Gavilast will be supported by a £600,000 radio campaign starting next wee and running through December.

The radio commercial features the Gavilast devil who delights in the chance to torture sufferers wi hellish heartburn. It is part of a £3 million TV campaign for Gavilast which started in October and will continue into the new year.

For more information:
Reckitt Benckiser plc
Tel: 01793 732000.

Inbrief

Cold comfort

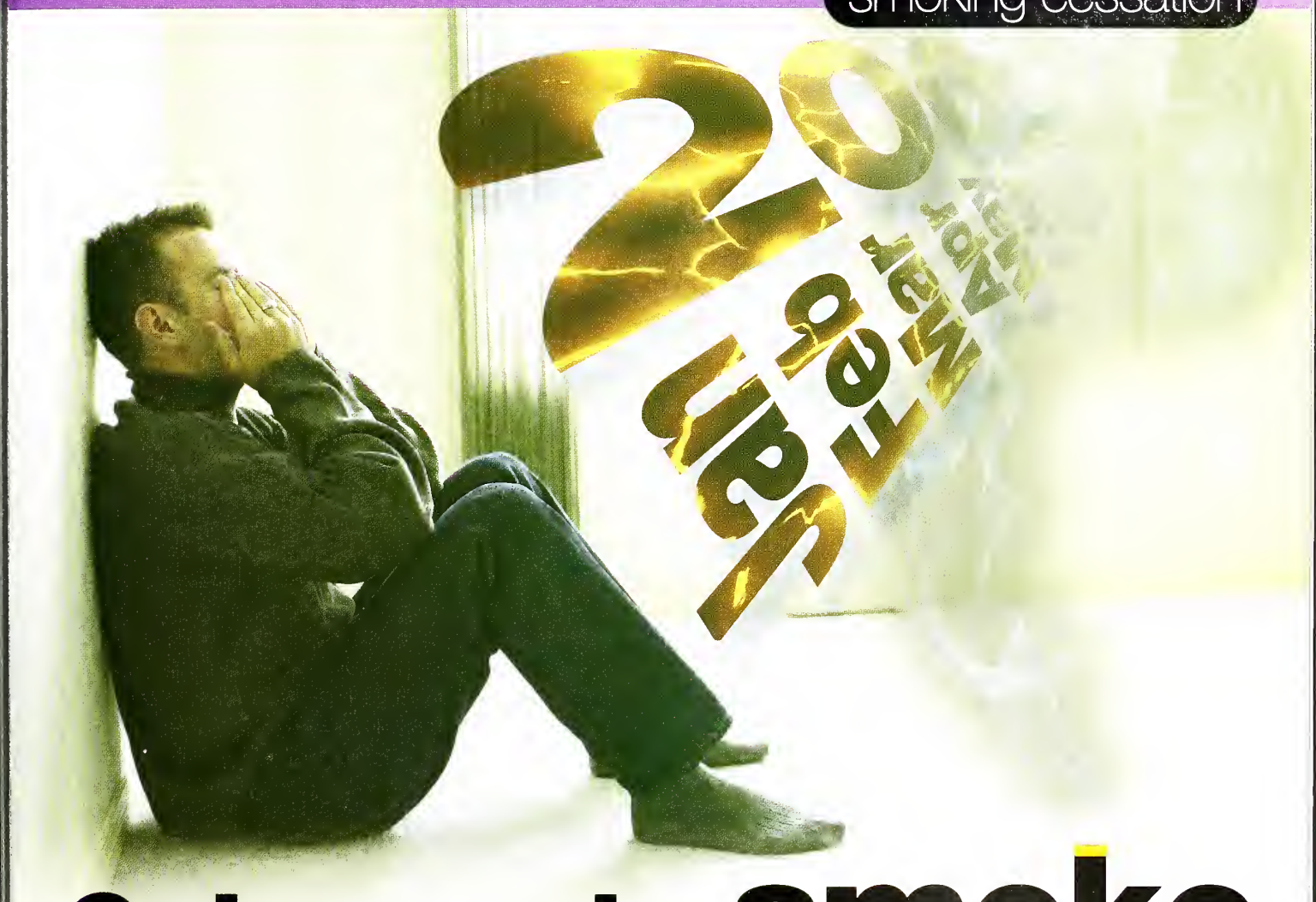
A new microsite for Olbas for Children has been designed to provide advice for parents on hov to deal with children's colds.

For more information:
www.olbas.co.uk/children

Xmas promotion

C&G Vitamin Centre is running a 'buy six get one free' Christmas offer on its vitamins, minerals, amino acids and organic herb range. The promotion will run unti December 23.

For more information:
Tel: 0845 330 2205.



Going up in smoke

As New Year approaches, giving up smoking will be one resolution many people will be making. Sarah Purcell looks at how the pharmacist can help prevent those resolutions from being broken

In the UK some 29 per cent of men and 25 per cent of women are smokers, yet 70 per cent of them would like to quit, according to the charity Action on Smoking and Health (ASH). So why is it that only 20 per cent of those who give up manage to quit for a year or longer? Is there more you as a pharmacist could be doing to help smokers give up permanently?

Powerful addiction

Nicotine is addictive and most people will need help with quitting. "Of the 70 per cent of smokers who want to give up, only 3 per cent manage it using willpower alone," says Dr Alex Bobak, chair of Smoking Cessation Action in Primary Care (SCAPE).

A report on nicotine addiction by the Royal College of Physicians concluded: "Nicotine has been shown to have effects on brain dopamine systems similar to drugs such as heroin and cocaine." And many experts believe cigarettes are even more addictive than class A drugs. When inhaled, nicotine goes straight into the lungs and is taken to the brain in just seven seconds, faster than heroin or cocaine can be absorbed.

The power of smoking is such that even after suffering serious smoking-related diseases, many persist. According to the journal *Psychopharmacology*, 40 per cent of those who have had a laryngectomy try to smoke soon afterwards and 50 per cent of lung cancer patients resume smoking after surgery.

The average smoker in Britain smokes 14 cigarettes a day, says ASH, and only one in 20 smokes less often than daily. One of the main indications of addiction is the time from waking to first cigarette – 15 per cent of smokers light up within five minutes of waking and half within the first hour of the day.

In the Health Development Agency's report *Meeting Department of Health Smoking Cessation Targets*, the importance of the pharmacy role is emphasised. "These groups have been in the vanguard of smoking cessation services and have a critical role in providing brief opportunistic advice and, where appropriate, in becoming smoking cessation specialists. For the cadre as a whole it is important they have accurate information about smoking as it relates to the patient groups they see, and can raise the topic of smoking, encourage smokers to make a quit attempt, and try to ensure they obtain help from the relevant services."

Dr Bobak is convinced of the importance of intervention by health professionals: "Seeing your GP or pharmacist for advice on smoking cessation definitely makes a difference and trials have shown that this increases your chances of a successful quit attempt."

At ASH, Naj Dehlavi agrees: "Lots of smokers don't know about the range of smoking cessation aids available or how to use them and the information you can provide is important. Pharmacists are experts in recommending the right product to suit the individual as well as helping with motivation."

Meeting the DoH targets

The Department of Health's target is for primary care trusts to get 800,000 smokers to quit successfully at the four-week stage by 2006, which is a 170 per cent increase on the current figure. This will be a considerable burden on GPs, and

Continued on page 34

pharmacists are expected to share some of the load.

More funding has been allocated to smoking cessation to meet these targets and some of this is expected to be channelled into the pharmacy sector through the new pharmacy contract scheme, due to commence next April. "The extra funding that pharmacists will receive for providing smoking cessation services is under negotiation and they'll be asked to ballot on it shortly," says pharmacist and Pharmacy HealthLink vice-chairman Terry Maguire. "The new contract will help to formalise what pharmacists can do to get more involved in smoking cessation schemes."

The most important element for pharmacists who want to take on a wider role in smoking cessation is training for themselves and their staff, says Dr Maguire. Training and advice on setting up a smoking cessation clinic in your pharmacy is available from the Health Development Agency, organisations such as Quit and ASH, as well as manufacturers of smoking cessation aids.

Dr Bobak says pharmacists can provide help with motivation as well as advice at the initial quit attempt. "Pharmacists can capitalise on the personal relationship they have with their customers by tactfully asking how their quit attempt is progressing and offering help if needed."

Craig Shaw, brand manager for Nicotinell at Novartis, says: "Smokers will only quit when they're ready to, but pharmacists can provide active encouragement when they want to give up."

At GlaxoSmithkline, marketing manager Mark Dickenson believes smoking cessation is an ideal area for pharmacists to get more involved: "You can be reactive to requests from customers or pro-active in offering help with giving up when you hand out prescriptions that are for conditions linked with smoking such as heart disease and diabetes." He suggests following the simple approach favoured by SCAPE: "They use a three question, 30 second approach, which you can use when handing out relevant prescriptions. Ask customers: Do you smoke? Do you want to give up? Would you like help with giving up?"

Raising awareness of smoking cessation aids is a way that every pharmacy could get more involved. "An estimated 95 per cent of smokers are addicted to the nicotine in cigarettes and they'll need help with giving it up," says Dr Bobak.

There's no miracle cure, and what helps one smoker to quit may not work for another. "You can help by encouraging smokers to try several cessation methods until they find the one which suits them," say Naj Dehlavi at ASH.

Pregnant smokers

Almost a third of women in the UK who smoke continue to do so when pregnant. The Department of Health wants to reduce the number of pregnant smokers by 1 per cent a year and a national smoking in pregnancy initiative has been underway since April 2001. Dr Bobak believes pharmacists could get more involved at the pre-conception stage, tactfully raising the issue of smoking when women purchase folic acid supplements. "This really is an opportune time to pass on the message about the dangers of smoking in pregnancy to women – handing out a leaflet and raising the issue could be the trigger they need."

Specialist help is available to support pregnant smokers either locally through health visitors and midwives, through the NHS helpline (0800 1699169) or Quit Line for pregnant smokers (0800 002200).

"Many women still aren't aware of the real dangers that smoking poses for their unborn baby – it's not just about low birth weight," says Naj Dehlavi at ASH. "Don't just assume that pregnant smokers know what they're doing."

- The risk of miscarriage increases by 27 per cent, while the baby is a third more likely to be still born.
- The baby is 50 per cent more likely to be premature, which increases long-term risks to its health.
- The baby is three times more likely to be a low birth weight, which puts them at a higher risk of cot death and of heart disease in later life.
- They're more likely to have breathing difficulties after birth, and if mothers continue to smoke their risk of chest infections, asthma and glue ear is much higher than babies of non-smokers.

Get more from smoking cessation aids

The use of nicotine replacement therapy (NRT) or bupropion (Zyban) can double the chance of quitting successfully, but these aids are still underused.

Safety concerns highlighted by the media about the use of Zyban has meant that the drug hasn't been as popular as anticipated, despite the fact that a review by the European Agency for the Evaluation of Medicinal Products found it has a favourable risk/benefit profile.

The most important element for pharmacists who want to take on a wider role in smoking cessation is training

"I think part of the problem is that people expected a smoking cessation drug to be free of side effects, when of course no drug is completely without side effects," says Mr Maguire.

Revised NICE guidelines mean that NRT can now be recommended by a health professional to pregnant smokers where the only alternative is to continue smoking. In France NRT can now be given to patients with heart conditions where the benefits outweigh the risk of smoking. "There is some good evidence for the use of NRT by smokers while cutting down the number of cigarettes they smoke, but we need to see changes in licensing before we can act on this," says Dr Maguire.

Dr Bobak emphasises the importance of offering support as well as smoking cessation aids. "The three keys to getting a smoker to quit are motivation, support and treatment. NRT and Zyban work, but they're so often dished out without proper support."

Pharmacy is still the main source of NRT advice, accounting for 70 per cent of sales. "However, grocery is seeing growth in this sector and pharmacists need to capitalise on the personal service and advice that they can offer to protect their market," says Craig Shaw. "Pharmacies are ideally placed to offer support to smokers as they're more easily accessible than doctors' surgeries."

The new Smokerlyzer System is another useful aid, which is now available for smokers to use at home as part of their smoking cessation programme. The system measures carbon monoxide levels in the

Continued on page 36 ▶

NiQuitin CQ 4 mg Mint Lozenge Pro
Information. Presentation: White Loze
containing 4 mg nicotine. **Indication:** Reli
nicotine withdrawal symptoms, inclu
cravings, associated with smoking cessa
Use with behavioural support program
Dosage: *Adults only:* 4 mg lozenge if tim
first cigarette ≤ 30 minutes of waking.
smoking completely. Weeks 1 to 6; 1 loze
every 1 to 2 hours (min. 9 max. 15/
weeks 7 to 9; 1 lozenge every 2 to 4 h
weeks 10 to 12; 1 lozenge every 4 to 8 h
Weeks 13-24, use 1 to 2 lozenges per
only when strongly tempted to sm
Contraindications: non-smokers, chil
and adolescents under 18, phenylketon
recent heart attack or stroke, severe irreg
heartbeat, unstable or worsening ang
resting angina. Hypersensitivity to nicotin
other ingredients. **Precautions:** hyperten
peptic ulcer, severe kidney or liver impairm
phaeochromocytoma, hyperthyroidism, diab
cardiovascular disease (e.g. heart fai
stable angina, cerebrovascular dise
vasospastic diseases, occlusive periph
arterial disease). Active oesophagitis, ora
pharyngeal inflammation, gastritis or pe
ulcer may experience symptom exacerba
Interactions: Concomitant medication
need dose adjustment; caffeine, theophyl
imipramine, pentazocine, phenace
phenylbutazone, insulin, tacrine, clomipran
olanzapine, fluvoxamine, flecainide
adrenergic blockers (e.g. propranolol)
need dose decrease; adrenergic agonists
salbutamol) may need dose increa
Propoxyphene, frusemide and H_2-antago
may also require dosage adjustment
smoking may alter their effects. **Side effe**
Headache, dizziness, mood swings, irritab
anxiety, insomnia, nausea, vomiting, dyspep
hiccup, flatulence, diarrhoea, constipat
appetite changes, mouth irritation/ulcerat
pharyngitis, coughing, wakefulness. Uncom
adverse events include general malaise,
rashes, itching, sweating, gingival or r
bleed, palpitations, tachycardia, chest p
flushing, nasal or throat irritation, c
infection, dyspnoea, asthma exacerbation, t
disturbance, halitosis, gagging, lip sorenes
ulceration, tooth or jaw ache, oesopha
reflux, peptic ulcer, abdominal cramps, exces
thirst, nocturia, lightheadedness, nightma
restlessness, migraine, sensory disturba
Pregnancy/lactation: not recommend
Legal category: GSL. **Product licen**
number: PL 00079/0374. **Product licen**
holder: GlaxoSmithKline Consumer Healthc
Brentford, TW8 9GS, U.K. **Pack size and R**
36 lozenges £8.99, 72 lozenges £17.49. **D**
of last revision: August 2003. **NiQuitin**
CQ and **Committed Quitters** are registe
trade marks of the GlaxoSmithKline group
companies.

“PACKET IN ”

New NiQuitin CQ® 4mg Mint Lozenge

The unsurpassed efficacy of original NiQuitin CQ® Lozenge, in a fresh new flavour.

For those who smoke within 30 minutes of waking, this power, combined with your support, could be just what they need to quit.

Nicotine

Help bring smoking to a full stop

smoker's breath, giving visible proof of the damage that smoking is doing to the body. By being able to monitor the lowering levels of CO as they give up smoking, the system can be a useful motivational aid. It can be used in conjunction with any smoking cessation method and comes with a quit manual and advice on proven therapies such as NRT and Zyban.

"The system gives access to a way of measuring CO levels without having to see a GP, and anything that gives people better access to means of quitting is a positive step. Putting it in the pharmacy domain does this, and pharmacists can recommend it at the same time as they advise on NRT or Zyban," says Dr Bobak.

Second-hand smoke

Some 42 per cent of children live in a house where at least one person smokes, according to the Department of Health, and a third of smokers continue to smoke when near children. Every year 17,000 children under five are admitted to hospital with illnesses which are the result of passive smoking, and it seems few parents are aware of the real dangers involved – a poll for SmokeFree London found that only 3 per cent of parents knew cot death could result from passive smoking and only 1 per cent linked glue ear with passive smoking.

The World Health Organization estimates that almost half the world's children are exposed to tobacco smoke by the 1.2 billion adults who smoke. Children from lower income households are more at risk – 54 per cent are exposed compared with 18 per cent in professional households.

Children are more susceptible to the effects of passive smoking. Their bronchial tubes are narrower and they breathe faster than adults, so they take in more harmful chemicals in relation to their weight than adults do. Their immune systems are less developed, making them more prone to respiratory and ear infections when exposed to tobacco smoke. A recent study in Hong Kong found that babies who live with two or more smokers are 30 per cent more likely to need hospital treatment than those in smoke-free homes.

There is evidence to suggest passive smoking is an important risk factor in the development of asthma in children, as well as contributing to the severity of attacks. In Britain it is thought that between 1,600 and 5,400 new cases of asthma occur each year as a result of parental smoking, according to ASH. Passive smoking is also thought to be linked to bronchitis, pneumonia, middle ear infection and cot death. Children of mothers who smoke are five times more at risk from cot death than those of non-smokers, while parental smoking increases the risk of middle ear disease by 20-40 per cent.

As part of the Government's Tobacco Information Campaign, *Second-hand Smoke: Smoking Near Children* is a new phase designed to raise awareness of the dangers of smoking around children. It combines television advertising with press and PR activity.

"Pharmacists could do more to help raise awareness among parents. They could, for example, mention the importance of not smoking around children who are asthmatic or have cystic fibrosis to parents who are collecting prescriptions for children with these conditions. However, it needs to be done tactfully to avoid attaching any blame to parents for the child's condition," says Mr Maguire.

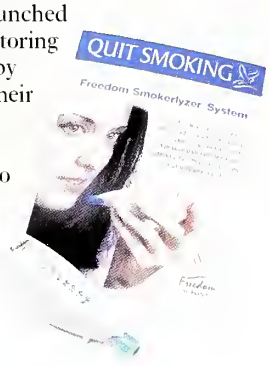
How soon do you light up?

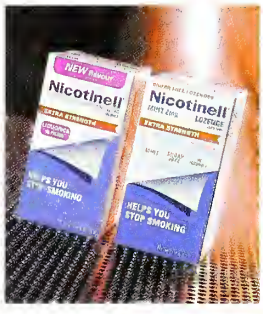
Asking smokers how soon they light their first cigarette after waking could be a better indication of how addicted they are to cigarettes than the number they smoke per day, according to a new study (*Monaldi Arch Chest Dis 2003; 59:1, 91-94*).

The study suggests this indicator of dependence should be used when advising on the correct strength of NRT. Smokers who light up within 30 minutes of waking are highly dependent on nicotine and need the higher strength NRT. Smokers who light up 30 minutes or more after waking are less dependent and should be recommended the lower strength NRT.

Cessation aids news

Bedfont Scientific has launched a carbon monoxide monitoring system that can be used by smokers at home to aid their quit attempt. The Smokerlyszer System (£39.99) helps smokers to estimate their level of nicotine dependence by measuring the amount of carbon monoxide in their breath. It comes with a quit manual written by smoking cessation expert Nicky Willis. Bedfont Scientific, tel: 01634 673720.





New to the Nicotinell NRT range are Liquorice coated gum and Extra Strength Mint lozenge. The Liquorice-coated gum is available in 2mg and 4mg strengths and pack sizes of 24 and 96. The Extra Strength Mint lozenge is available in a 2mg strength for those who smoke 30 or more cigarettes a day and comes in pack sizes of 12, 36 and 96. Novartis Consumer Health, tel: 01403 210211.

NiQuitin CQ is now available in a 2mg and 4mg mint flavour lozenge. The new lozenge uses the same method of dosing as the original lozenge and gum – time to first cigarette – to gauge the right dosage for the smoker. The launch is being supported by a marketing campaign including posters from December. GlaxoSmithkline, tel: 020 8047 2700.

Nicobloc is a natural smoking cessation method to allow smokers to give up gradually. The syrup is applied to the filter of a cigarette before smoking to prevent up to 33 per cent (over the course of a week) of tar and nicotine from being inhaled. It can be safely used by pregnant women and those on medication. Rosen Holdings, tel: 0845 130 7848.

Continued on page 38 ▶

Nicorette Patch is specifically designed to be taken off at bedtime, so the body gets a break. It's a discreet, easy-to-use, once-a-day dose available in three strengths so your customers can gradually reduce their nicotine intake. The new Nicorette Patch TV campaign featuring the benefit of "the patch you take off at night" starts soon. So give your customers Nicorette Patch and help them beat cigarettes one at a time.

You're twice as likely to succeed with

nicorette®

patch

A new survey by Nicorette found that 88 per cent of smokers and ex-smokers welcomed advice from the pharmacy about giving up their habit. An important point to remember, says the company, is that without correct advice customers using NRT gum regularly under-dose, which can result in a higher risk of relapse. Those who smoke 20 cigarettes a day should use the 4mg gum and those who smoke less, the 2mg gum. Pharmacia, tel: 01908 661101.

The Honeyrose Method encourages smokers to follow a three-week plan, in which they swap from their regular cigarettes to herbal cigarettes, and then gradually reduce the herbal cigarettes they smoke until they can do without.

Honeyrose Herbal cigarettes are made from a blend of natural herbs, are non-addictive and nicotine-free. There are six flavours to choose from. Honeyrose Products Ltd, tel: 01449 612137.

IntraPharmQ smoking survey

Ninety five per cent of pharmacists do not smoke, according to a *C&D* online smoking cessation survey on IntraPharmQ.

The results of the survey also show that over a quarter of pharmacists have first-hand experience of quitting. A fifth of all respondents have successfully kicked the habit.

The results from 185 community pharmacists show that while all respondents offer quitting advice to their customers, only 24 per cent run smoking cessation clinics through their pharmacies.

The questionnaire also asked which formulation of nicotine replacement therapy pharmacists tended to recommend, and which were asked for by patients. The table compares pharmacists and patients' choice of NRT formulation.

Formulation	Percentage of pharmacists recommending formulation	Percentage of patients requesting formulation
Patch	64	83
Gum	5	15
Lozenge	4	0.5
Inhalator	0.5	2
Microtabs	0	0.5
Nasal spray	0	0
Unspecified	27	0

Although patches appear the most popular product, both on pharmacist recommendation and patient selection, only 39 per cent of survey respondents recommend a preferred brand of NRT. The proportion of respondents preferring each individual brand are shown in the table.

Brand	Percentage of respondents stating a brand preference
NiQuitinCQ	66
Nicorette	24
Nicotinell	10

Thirty two per cent of the remaining 61 per cent of pharmacists said that their preferred NRT brand differs according to the formulations available in each range. However, 29 per cent of pharmacists said they have no brand preference at all.

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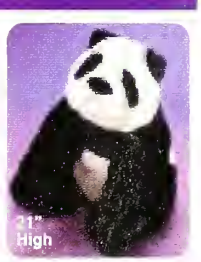

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Sara Vincent


Trevor Davis

Alpharma has appointed **Sara Vincent** as UK sales and marketing director. Ms Vincent has broad experience in the field as her previous job was business unit director for Novartis UK.

Also joining Alpharma is **Cass Khan** in the role of brand/hospital project manager. Mr Khan moves from Pharmacia where he was commercial manager for mature brands and well-established generics.

Trevor Davis has been appointed non-executive director at ADL Healthcare. Prior to this appointment, Mr Davis was managing director and chief operating office at Shire Pharmaceuticals, and has experience with Eli Lilly and Wyeth Labs.

Reckitt Benckiser plc has appointed **Ken Hydon** as an independent non-executive director. Mr Hydon joins from Vodafone Group plc, where he was financial director.

Celltech Group plc has announced the appointment of **Grahaem Brown** as director of development. Prior to this, Dr Brown was head of clinical operations at Pfizer, and has 20 years of experience in the pharmaceutical industry, having held positions at Pharmacia, Novartis and Glaxo.

Sophie Gasperment has been appointed managing director for L'Oreal's consumer and professional products divisions in the UK. She takes over from **Geoff Skingsley** who will move to Paris to take up the position of deputy director general of L'Oreal's global human resources. Ms Gasperment was previously general manager o the L'Oreal Paris brand in the UK.

Pharmacist going for triathlon gold

Pharmacist Nicola Lord will put all thoughts of work behind her this weekend when she competes in the World Triathlon championships.

Nicola will be flying out to Queenstown, New Zealand, with the other 300 members of the British team to compete in the women's 35-39 event. The 24 events are expected to attract over 1,500 competitors from 50 countries, and it will be Nicola's first attempt at international level since taking up the sport seven years ago. The event comprises a one mile swim, followed by a 26 mile cycle, and finishes with a 10km run.

Nicola is more usually seen at the United Co-op Healthcare pharmacy in Oldham, Greater Manchester, and her bid for glory has been supported by a £2,000 grant from the Co-operative Society's Charitable Foundation.

Pharmacist wins Quit award

Nilesh Shah, pictured above with Quit chief executive Steve Crone (left) and Novartis Consumer Health sales director David Francis has been named Smoking Cessation Supporter of the Year a the 2003 Quitter of the Year awards

Mr Shah was quoted as being "head and shoulders above his fellow competitors", by a member of the judging panel. He has provided a smoking cessation service from his pharmacy in Princes Risborough, Bucks, since 1993. Patients are encouraged to draw up their own quit plan and return to Bells Pharmacy on a weekly basis for counselling, carbon monoxide monitoring and products.

Mr Shah says that 70 per cent of his clients have successfully quit at four weeks. This drops off to 63 per cent after three months, and averages 24 per cent after one year. His first client has now been a non-smoker for 10 years.

Presenting the award, TV's John Stapleton praised the "fantastic work of all health professionals" in this field. Accepting his prize, Mr Shah said "I am glad the profession is being recognised for its work in this area."

There's something different about you...

A New Zealand study into the effects on women whose partners have taken Viagra has had some surprising results.

Several women reported being worried about the sudden change in their partner's behaviour as they didn't know the man was taking the drug. Other women felt so pressurised into resuming frequent sexual relations they considered seeking treatment.

Some women were so fearful that their partner would have a heart attack during or after sex that they were unable to relax and enjoy sex.

The research published in the journal *Sociology of Health & Illness* concluded that Viagra should not be prescribed until the man's partner has been consulted.

This year's Phoenix and NTL sponsored class c golf tournament was held last month at the famous Turnberry course in Ayrshire, Scotland. The event was won by the team comprising Phoenix sales representative Peter Shadwick and pharmacists Anup Patel from Bognor Regis, Manvir Patel from Reading and Rex Allott from Marlow. The trophy is currently sitting on the dispensary divide of Rex's pharmacy, and he is negotiating with the rest of his team to keep it there until next year's event. Pictured holding the cup are the winning team of (from left): Rex Allott, Manvir Patel, Peter Shadwick and Anup Patel with Phoenix chief executive officer David Cole (far left) and NTL's John Ross (far right)

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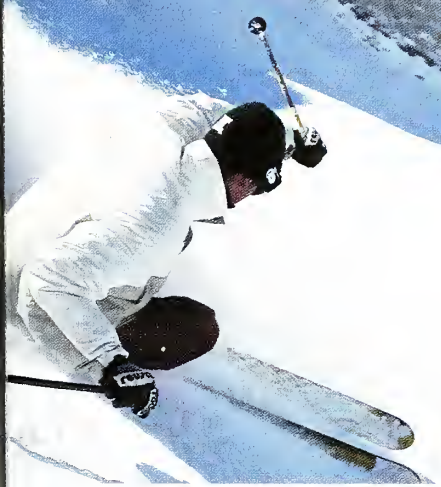

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The prize is for a couple sharing a twin/double room and it can be taken any time between 15 January and 31 March 2004 (subject to availability). It includes return flights from Heathrow or Gatwick, accommodation for three nights at a centrally situated 4-star resort hotel, half board meals and airport transfers.

Rules 1 This competition is open to any pharmacist or permanent member of staff who works at an address which receives either *Chemist & Druggist* or *Community Pharmacy* 2 Competitors may enter through *C&D* or *Community Pharmacy*, but may only submit one entry. Double entry will disqualify both entries 3 Entries must be on an original coupon from *C&D* or *Community Pharmacy*, and to be eligible for the prize entrants must correctly answer the question on the coupon 4 The prize offered will be as stated. No alternative holidays or cash prizes will be offered 5 Names of winners will be published in *C&D* and *Community Pharmacy* 6 In any dispute, the decision of CMP Information Pharmacy Group's publishing director will be final and no correspondence will be entered into 7 Employees of CMP Information Ltd, Travel Clubs International and trading divisions and their immediate families are forbidden to enter 8 No purchase is necessary to participate 9 The closing date for this month's competition is as printed on the entry coupon

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